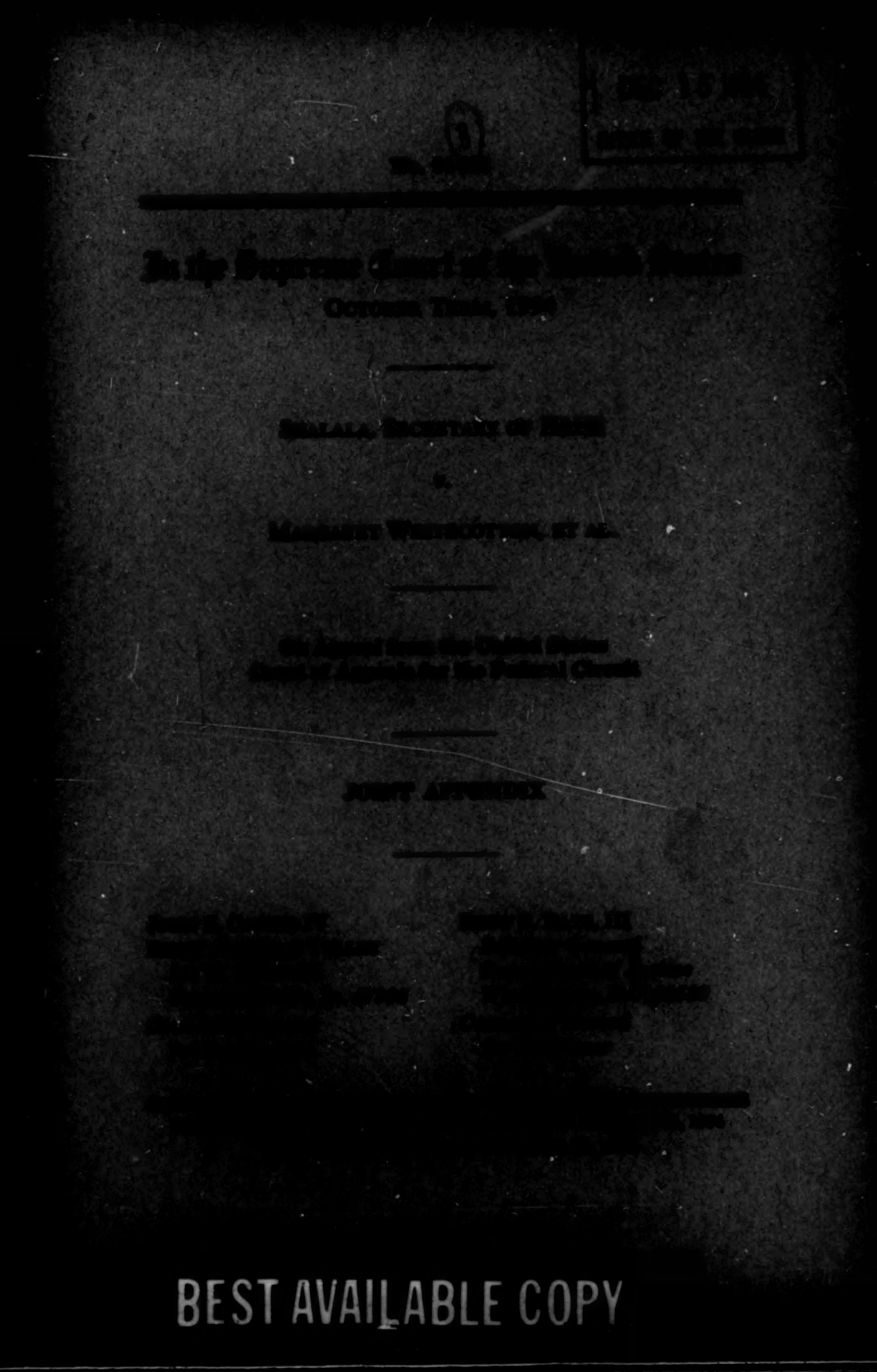

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UNITED STATES FEDERAL COURT
OF FEDERAL CLAIMS

Civil Docket for Case #: 90-VV-692

MARGARET WHITECOTTON, ET AL., PLAINTIFF

v.

DONNA E. SHALALA, SECRETARY OF H&HS,
DEFENDANT

DOCKET ENTRIES

DATE	PROCEEDINGS
Jul 24 1990	Filing fee of $120 paid by petitioners.
Jul 24 1990	Notice of assignment to Special Master Paul Baird filed. Copy to parties.
Jul 31 1990	Respondent's notice of appearance filed. Service: 7/30/90.
Aug 1 1990	Petitioners' notice of filing Exhibit J, contained in three binders, filed. Service: 7/31/90.
Aug 2 1990	Special Master's notice to parties re proceedings filed. Copy to parties.
Oct 1 1990	Petitioners' notice of filing document (Exhibit K) filed. Service: 10/9/90.
Oct 22 1990	Respondent's notice of appearance filed. Service: 10/19/90.
Oct 22 1990	Special Master's order suspending proceedings for 30 days; and directing respondent to file report by November 21, 1990 filed. Copy to parties.

DATE	PROCEEDINGS
Nov 21 1990	Special Master's order entered suspending proceedings for 30 days, with respondent's report due DEC 21 1990. Copy to parties.
Dec 21 1990	Respondent's report filed. Service: 12/21/90.
Jan 7 1991	Order scheduling status conference; further proceedings; and directing parties to file one copy with original documents filed. Copy to parties.
Jan 23 1991	Special Master's order entered scheduling a status conference and a hearing re entitlement. Copy to parties.
Feb 6 1991	Respondent's notice of filing (Exhibit B, curriculum vitae) filed. Service: 2/5/91.
Feb 11 1991	Order entered suspending proceedings for 60 days, and vacating April 4 hearing date. Copy to parties.
Apr 18 1991	Order scheduling hearing; scheduling prehearing conference; each party to file prehearing memorandum, witness list, and exhibit list by May 21, 1991 filed. Copy to parties.
May 21 1991	Respondent's pre-hearing memorandum, witness and exhibit list filed. Service: 5/21/91.
May 28 1991	Special Master's order entered rescheduling prehearing conference. Copy to parties.
May 31 1991	Petitioner's prehearing memorandum, witness and exhibit list with (exhibits L-N) filed. Service: 5/30/91.
Jun 10 1991	Petitioner's exhibits 53 through 56 filed. Service: 6/7/91.
June 18 1991	Petitioner's exhibits Q, R, S, T, & U filed. Service: 5/14/91.

DATE	PROCEEDINGS
June 19 1991	Transcript of proceedings (1 volume) taken at Indianapolis, Indiana, on June 4, 1991; together with petitioner's exhibits 0-1 through 0-9 and 1 and 2 filed. Notice to parties.
Jul 3 1991	Petitioner's affidavit of John S. Capper IV filed. Service: 7/2/91.
Jul 3 1991	Petitioner's exhibit V filed. Service: 7/1/91.
Jul 17 1991	Order that respondent file written source of authority in 7 days; petitioners may respond 10 days from filing; and suspending proceedings for 30 days filed. Copy to parties.
Jul 24 1991	Respondent's notice of filing exhibits 57-59 filed. Service: 7/23/91.
Aug 13 1991	Petitioner's notice of filing exhibit W filed. Service: 8/12/91.
Aug 16 1991	Special Master's decision filed. Copy to parties with petitioner served via Fed Ex.
Sep 16 1991	Petitioner's motion for review of the special master's decision filed. Service: 9/13/91, Judge and SM.
Sep 16 1991	Notice of assignment to Judge James T. Turner filed. Copy to parties, Judge and SM.
Oct 16 1991	Respondent's response to motion for review filed. Service: 10/16/91 SM and Judge.
Jan 14 1992	Judge's opinion and order overruling petitioner's objections to special master's decision; and directing Clerk to enter judgment for respondent in accordance to special master's 8/16/91 decision filed. Copy to parties with petitioner served via Fed Ex. Copy to SM.

DATE	PROCEEDINGS
Jan 29 1992	Judgment entered that the petition is dismissed. Copy to parties. Judge & SM.
Mar 30 1992	Petitioner's motion to set aside judgment and for rehearing filed pursuant to Rule 60(b). Service: 3/27/92. Copy to SM.
Apr 1 1992	Notice of filing petition for review in the CAFC on March 27, 1992, received. C.A.F.C. #92-5083. Copy to Judge and SM.
Apr 13 1992	Respondent's brief in response to petitioners' motion to set aside judgment and for rehearing filed. Service: 4/13/92.
Jun 2 1992	Respondent's notice of appearance filed. Service: 6/2/92.
Jun 26 1992	Order from the CAFC entered staying proceedings pending ruling on Claims Court ruling on its 60(b) motion etc. Copy to parties. Judge and SM.
Jul 1 1992	Judge's order of remand to the Special Master filed. Copy to parties and to SM.
Aug 25 1992	Petitioner's amended Table of Contents filed by leave of the Judge.
Aug 25 1992	Petitioner's verified motion for leave to file amended and supplemental motion under Rules 59 and 60(b); motion for procedural ruling and for evidentiary hearing; etc. filed by leave of the Judge. Service: 8/21/92. SEE ORDER ENTERED AUG 25 1992.
Aug 25 1992	Order entered granting petitioner's motion for leave to file amended and supplemental motion under Rules 59 and 60(b), etc., with respondent afforded 14 days from the date of filing to respond. Copy to parties.

DATE	PROCEEDINGS
Aug 25 1992	Petitioner's amended and supplemental motion under Rules 59 and 60(b); motion for procedural ruling and for evidentiary hearing; etc. filed. SEE ORDER ENTERED AUG 25 1992.
Aug 25 1992	Respondent's response to petitioner's amended motion under RUSCC 60(b) filed. Service: 8/17/92.
Aug 25 1992	Judge's order entered denying petitioner's motion to reverse the remand or for relief from judgment, and confirming in all respects the order of remand entered July 1, 1992. Copy to parties and to SM.
Sep 15 1992	Order entered denying petitioner's motion for leave to file amended and supplemental motion under Rules 59 and 60(b), etc. Copy to parties and to Judge.
Oct 15 1992	Petitioners' motion for review, and in the alternative, for order rejecting special master's "report" on Rule 60(b) proceedings filed. Service: 10/14/92.
Oct 15 1992	Petitioners' motion for leave to file overlength memorandum of objections in support of motion for review, etc. filed. Service: 10/14/92. GRANTED BY ORDER ENTERED OCT 20 1992. Copy to parties.
Oct 20 1992	Petitioner's overlength memorandum of objections in support of motion for review filed.
Nov 16 1992	Respondent's response to petitioners' motion for review filed. Service: 11/16/92.
Jan 7 1993	Judge's opinion and order entered denying petitioner's motion for relief from judgment pursuant to RCFC 60(b)(2). Copy to parties and to SM.

DATE	PROCEEDINGS
Jan 12 1993	Judgment entered that the petition is dismissed. Copy to parties.
Feb 4 1993	Corrected judgment entered that petitioners' motion to vacate the judgment of 1/29/92 is denied. Copy to parties Judge and SM.
Mar 18 1993	Notice of filing petition for review by petitioner's, CAFC #93-5101 received. Copy to Special Master and Judge.

U.S. DISTRICT COURT
UNITED STATES COURT OF FEDERAL CLAIMS
(U.S.C.F.C.)

Civil Docket for Case #: 90-VV-692

WHITECOTTON, ET AL.

v.

HHS

DOCKET ENTRIES

DATE	Nr.	PROCEEDINGS
7/24/90	1	PETITION by MARGARET WHITECOTTON, KAY WHITECOTTON, MICHAEL WHITECOTTON FILING FEE $120 Vac. Date: 08/18/75 (pf) [Entry date 03/16/94]
7/24/90	—	CASE assigned to Judge Unassigned. (pf) [Entry date 03/16/94]
7/24/90	2	NOTICE OF assigned to Special Master Paul Baird. Copy to parties. (pf) [Entry date 03/16/94]
9/16/91	3	Notice of assignment to Judge James T. Turner. Copy to parties. (pf) [Entry date 03/16/94]
1/14/92	4	UNPUBLISHED DECISION entered overruling petitioner's objections to Special Master's August 16, 1991 decision, and Dismissing the petition (signed by Judge James T. Turner). Copy to parties. (tw) [Entry date 05/04/94]

DATE	Nr.	PROCEEDINGS
1/29/92	6	JUDGMENT entered that the petition is dismissed. (signed by Clerk). Copy to parties, Judge, and Special Master. (bh) [Entry date 03/23/94]
1/29/92	—	Case closed. (bh) [Entry date 03/23/94]
3/18/93	8	NOTICE FROM CAFC re: filing of Petition for Review by MARGARET WHITECOTTON, KAY WHITECOTTON, MICHAEL WHITECOTTON CAFC #93-5101 received. (hw) [Entry date 09/07/94]
3/15/94	4	See case No. 90-551v for notice to parties re: resignation of Special Master Baird (pf) [Entry date 03/16/94]
5/6/94	5	MANDATE (certified copy) of the CAFC dated May 6, 1994, reversing and remanding the [7-1] petition for review filed by Margaret Whitecotton, Kay Whitecotton, and Michael Whitecotton (Vacate judgment deadline on 6/6/94). (hw) [Entry date 05/11/94]
5/6/94	7	MOTION by MARGARET WHITECOTTON, KAY WHITECOTTON, MICHAEL WHITECOTTON (Service:) For review of Special Master's Decision Judge James T. Turner (Judge's decision due on 9/6/94) Response due: 6/6/94 (rs) [Entry date 08/31/94]
5/11/94	6	ORDER entered Vacating [6-1] judgment order and remanding the case to Office of Special Master (signed by Judge James T. Turner). Copy to parties. (hw) [Entry date 05/12/94]
5/11/94	—	Case reopened. (hw) [Entry date 05/12/94]

DATE	Nr.	PROCEEDINGS
5/11/94	7	ORDER entered Vacating [6-1] judgment order, and remanding case to Special Master's for a determination of compensation pursuant to said opinion and mandate of the Federal Circuit Court of Appeals (signed by Judge James T. Turner). Copy to parties. (hw) [Entry date 05/20/94]
7/18/94	8	ORDER set Life Care Plan due: 9/12/94 for MICHAEL WHITECOTTON, et al. and directing Respondent to evaluate and contact court with two agreed upon dates for status conference no later than October 24, 1994 (signed by Chief Special Master Gary J. Golkiewicz). Copy to parties. (as) [Entry date 07/26/94]
9/12/94	9	MOTION by MARGARET WHITECOTTON (Service: 9/9/94) to Extend Time to file its life care plan [60 days]. Response due: 9/26/94 (as) [Entry date 09/13/94]
10/5/94	10	ORDER granting [9-1] motion to Extend Time to file its life care plan and reset Life Care Plan due: 11/14/94 for MICHAEL WHITECOTTON (signed by Chief Special Master Gary J. Golkiewicz). Copy to parties. (as) [Entry date 10/13/94]
11/28/94	11	MOTION by MARGARET WHITECOTTON, KAY WHITECOTTON, MICHAEL WHITECOTTON (Service: 11/21/94) to Stay of the deadline to file the life care plan (to 60 days). Response due: 12/8/94 (mp) [Entry date 11/30/94]

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

92-5083, 93-5101

MARGARET WHITECOTTON, by her next friends,
KAY WHITECOTTON and MICHAEL WHITECOTTON,
PETITIONERS-APPELLANTS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
RESPONDENT-APPELLEE

JUDGMENT

On appeal from the United States Court of Federal Claims in Case No(s). 90-692V,

This CAUSE having been heard and considered, it is

ORDERED and ADJUDGED:

REVERSED AND REMANDED

ENTERED BY ORDER OF THE COURT

/s/ Francis X. Gindhart
FRANCIS X. GINDHART
Clerk

Dated Feb. 15, 1994

ISSUED AS A MANDATE: May 6, 1994

STATE OF WEST VIRGINIA)
) ss:
COUNTY OF MAIDALL)

AFFIDAVIT

I, Ellen L. Kitts, M.D., after being duly sworn upon my oath, state the following:

Margaret (Maggie) Whitecotton was born April 22, 1975, following a normal prenatal course, normal labor, normal delivery. Apgars were 8 and 9. She was seen by her family physician, Dr. Shannon, at age three weeks, six weeks, two months, three months. All examinations were normal and she was deemed to be a normal child. On August 18, 1975, she received her third DPT injection and second oral polio vaccine. Her temperature (rectal) at the time of injection was 99.8-100 degrees. She developed a dime sized area of induration at the sight of the injection. On August 19, one day following her third DPT and second oral polio, Maggie developed clonic seizures with symmetrical limb jerking of the upper extremities. She stopped sucking and the pacifier dropped from her mouth. Her head tilted back. It was within twenty-four hours of that injection, following this her development slowed. The speed of growth of her head size slowed and fell off the growth curve. For all of the above reasons Maggie has post vaccine encephalopathy that presented with seizures twenty-four hours after the vaccination. Her encephalopathy has resulted in cerebral palsy, mental retardation, seizures, and she is non-verbal.

The diagnosis of post vaccine seizures and encephalopathy is confirmed by: the change in rate of head growth which slowed following the third vaccination, by reports by Dr. Keith Baird, and by the Marion County General Hospital discharge summary dictated by Stanley Wissman, M.D. It is important to note that on 3/24/80 she was admitted to the hospital with seizures following a DT im-

munization given the day before. She was well prior to the immunization. This indicates that the reaction may have been to the diptheria and/or the tetanus rather than the pertussis. But again a definite correlation exists between the vaccination and the seizures. There is no other causation for her condition.

I am able to report that generally Maggie is a very happy child. However, she has had significant pain and suffering as a result of her difficulties. She required surgery for a dislocated hip. This resulted in at least six weeks of being in a total body cast. Following the surgery she lost her ability to walk and this has not been regained.

Unfortunately the surgery was not successful. Another operation is being planned. Again there is significant amounts of pain often requiring narcotic pain medication during the first few days post operatively. She will again be required to wear a body cast for six to eight weeks. During which time she has no mobility. She is bed fast. She cannot attend school.

Maggie recently underwent a two stage spinal operation. This resulted in a several day stay in the intensive care unit. Following the initial surgery she was unable to sit up. There was considerable emotional suffering in that we were unable to explain the surgery, its reasons, or why she was hurting or how soon she would be better. Approximately two weeks later she underwent a second stage spinal operation. Again this resulted in a new onset of acute surgical pain. Within a reasonable degree of medical certainty Maggie will develop arthritis in the hip that has required the surgery. This will occur in early adult life (age 30 or 40, compared to age 50 or 60). This will then be present the rest of her life.

Based on Maggie's low intellect I doubt that she could separate out emotional stress from pain and suffering.

Maggie has cerebral palsy. She has already required one inpatient rehabilitation stay in an effort to better define her problems and help the family put together an

appropriate management strategy. At present she is receiving an appropriate outpatient program. It is my hope that at most she will require two other rehabilitation stays. The first will be to help her regain her ambulatory skills following her hip surgery. I would anticipate this stay lasting four to six weeks. A second rehabilitation stay may be required at the end of her education to help put together an appropriate prevocational/vocational program. It would look at her skills, her needs for specialized adaptive equipment and then would assist with job placement in a sheltered workshop. This would be done at a vocational rehab center. Maggie does require developmental evaluations and intellectual evaluations on an ongoing basis. With her placement in a special education setting IQ tests and psychological tests must be done every two years. In addition she did undergo a rehabilitation admission specifically for a developmental evaluation. At Maggie's age, these evaluations are done by an occupational therapy, physical therapy, speech and language therapy, an educator, and eventually a vocational rehabilitation specialist.

Maggie will require special education throughout her school years. She currently is functioning in a trainable mentally retarded setting. This will be ongoing until she reaches adult life. The problems are compounded by the fact that she is non-verbal. Thus it is even more difficult for those around her to know what she knows and understands. Much time and effort is being spent trying to create a communication system for her. Because she is non-verbal this makes vocational training and placement even more difficult.

Vocational training and placement outside a sheltered workshop is probably impossible. Maggie's low IQ significantly limits her job opportunities. This is compounded by the fact that she is non-verbal and therefore cannot ask questions, talk to other staff or clients, or make her ideas, wants or needs known. Her physical limitations will also be a significant factor. At present she is independently mobile in a manual wheelchair.

It is hoped that in time she will again become ambulatory but this is unknown. Her fine motor skills are somewhat slow and delayed and she is uncoordinated. As a result I feel the most advanced possible placement would be a sheltered workshop and this may be very difficult to find for her.

Based on my current assessment, Maggie will always require one to one supervision. She has a very short attention span and would not be able to stay on task. She needs constant twenty-four hour monitoring for seizures so that if one develops she can receive the appropriate help. This twenty-four hour attendant care would need to be performed by an appropriate attendant who is qualified to monitor seizures, give medication and respond approriately when a seizure occurs. In addition to this she needs one to one assistance for mobility, toileting, activities of daily living, etc. She will never be able to manage her own finances.

Any case as complex as Maggie does require a case manager. This person would help the family find appropriate therapists. They would help the family obtain and monitor appropriate one to one caregivers. They would help to coordinate all of her services. In addition to this they would help the family with coordination of all Maggie's bills. Case managers are frequently social service personnel, although at other times they are people who have worked in the insurance business or in medical rehab services.

Based on Maggie's low IQ, I doubt that she will ever need psychological counseling. However, her family, parents, and/or her siblings may well benefit from this at different points in their lives to help them adjust to Maggie and her disabilities. Counseling may also be necessary to help them adjust to the changes in their lives that are the result of Maggie's disability. As her parents get older Maggie's brother may need counseling and support as he decides the role that he will play in Maggie's life and her care.

Maggie currently is involved in a behavioral management program. At present this is being done through the school. However, in a sheltered workshop, group home environment, or in the home setting she may develop other behaviors that need to be modified or changed. If the family's routine measures are unsuccessful the specialist in behavior management will be consulted. Such specialists are usually psychologists. She would require intervention on a weekly basis for several months until the behaviors came under control.

It is in my recommendation to any family that at some point all children need to leave home. This certainly occurs at different ages and under different circumstances based on the family, the children and the disabilities the children exhibit. In leaving home the best possible option for Maggie would be a group home setting. These usually provide the lease restrictive environment compared to an extended care facility. Group homes work very hard to provide the clients with a day program that often is a sheltered workshop or job oriented. In the evenings the client's time is filled with routine housekeeping tasks, recreational activities, activities of daily living, interaction with relatives and peers. In each of these settings, Maggie will continue to need her own independent one-to-one care attendant.

If the family chooses to continue to have Maggie living in their home the extra support staff become even more important. Once Maggie reaches an appropriate age she needs independence from her parents and they need independence from their children. In order to maintain Maggie in their home this means that Maggie would still require twenty-four hour one-to-one attendant care as mentioned hereinabove. In this sort of a supervised setting the family could have their independence. Likewise Maggie too could be independent. It would increase Maggie's recreational activities, increase reinforcement of her educational setting and two people will be needed to assist her with her activities of daily living, transfers,

hygiene, etc. By living at home the family has to remain active in supervision the care takers, planning or supervising the care programs, making arrangements for the recreational activities and coordinating staff work schedules.

Maggie does require special equipment. At present she is non-ambulatory. As a result she needs an ultralightweight wheelchair with removal desk arms, swing away removable foot rests, heel loops, brake extensions, seat belt. Maggie also requires grab bars for the bath tub. If her final hip surgery is not successful she'll need help transferring in and out of the bathtub. This would be in the form of a hydraulic lift, a shower that is either wheelchair accessible or has a shower bench so that she can transfer laterally and shower in the sitting position would be the other alternative. Were the family ever to go on vacation and choose not to take Maggie with them she would then require round the clock care for management and supervision. She may need two people at times to help with dressing, hygiene, etc.

The residence does need to be wheelchair accessible. This means that areas need to be ramped. Hallways, doorways, etc., need to be extra wide. If Maggie is again to become ambulatory she will require a rolator walker. She may well require a Kaye posture control walker. Grab rails along the length of hallways may be necessary to provide support while walking.

Maggie does require exercise equipment that is enjoyable for her. Outdoor playground equipment such as swings would need to be modified to have a back as well as a seat. They should also have a seat belt. She will require an adult sized tricycle and/or bicycle with large training wheels to provide another means of independent mobility. Maggie is currently working on a communications system. At present this is a communication board. As she becomes more successful she may need a communication device that has synthesized speech. Such a device should be chosen that could interface with

a computer which would allow for increased recreational activities, increased educational activities, and synthesized speech. Maggie requires hydrotherapy in a heated pool. This is highly motivating for her. It increases strength, increases coordination, increases cardiovascular condition. The water must be heated to decrease her tone and relax her muscles. It is needed to assist with her range of motion program. It will be used post operatively to help her regain her ambulation. Because of the Indiana climate it must be a heated indoor pool.

Because of Maggie's cerebral palsy she should be seen by an orthopedist a minimum of every six months. She does need to be followed by a neurologist at least every six months to once a year. She needs to be seen by a family doctor and/or pediatrician a minimum of every six months to a year plus much more frequently whenever she would develop an illness. Although there have not been pediatric physiatrists in the area she would definitely benefit by seeing one again on an every six months basis. At present the closest people would be Chicago, Illinois, Columbus, Ohio, or Wheeling, W. Virginia. Because there are no specialists in Crawfordsville Maggie and her family have to travel a minimum of forty to fifty miles to have these appointments. This results in increased expenses for travel as well as increased phone bills.

In addition to this Maggie does need the chance to have time to be with her peers. She's an excellent candidate for Cerebral Palsy Camp, Sports by Ability Games, Special Olympics. Since it is very difficult for her to participate in many physical activities she requires social activities such as trips to the zoo or a Children's Museum. These activities need to have lots of visual stimuli, lots of activity, be very appealing to sight, sound and smell. There will always need to be tv as well as a VCR for entertainment.

I have seen Maggie Whitecotton during her inpatient rehabilitation stay at D.T. Watson Hospital, in the Meth-

odist Hospital rehabilitation clinic, and for two outpatient evaluations, one done in Indianapolis and the other done in Crawfordsville.

Maggie does have a normal adult life expectancy. Her seizures and cerebral palsy would not change her life expectancy in any way.

From a medical perspective Maggie has spastic quadriplegic cerebral palsy. The spasticity that came from the cerebral palsy has been enough to cause dislocation of her hip. The original surgery was not successful and the hip remains out. Following hip surgery the leg shortens. She may require surgery on the opposite leg to shorten it to develop and get a more equal leg length. If that is not necessary she will require special shoe lifts. If the lift is large enough it has to be attached to an ankle foot orthoses (brace) because the shoe itself cannot support the extra weight of the lift. Prior to the surgery Maggie was ambulatory. This skill has been lost. Now that her spinal surgery is complete we are in the process of getting appropriate orthopedic evaluations so that the surgical correction of her hip problem can be attempted again. Following hip surgery she will then require intensive rehabilitation treatment to help her regain ambulation. One more attempt needs to be made to put the hip back in the socket. If the hip is to remain out of the socket she will definitely develop early arthritis. This arthritis is made worse by the spasticity which chronically irritates the dislocated hip. It is very important to do this because she was ambulatory.

Because of the stiffness and spasticity, Maggie was never able to sit and fully extend her spine. She became contracted and eventually developed very severe kyphosis. This kyphosis causes a rounding of her spine such that it becomes impossible to look up. She is always looking at the floor. Were it not corrected she would lose her ability to sit. She would lose her ability to walk. She would not even be able to lie comfortably in bed because her spine would always be curved. This required two

different surgeries to correct. Without this surgery her back would have continued to curve. I'm happy to report that she has had an excellent surgical correction and is now doing well in her recovery phase.

We've talked about Maggie's limited intellect. At present she is functioning at about the equivalent of a two year old. This means that as an adult she will be functioning at the two and one-half to the three year old level. As a result she will always require adult supervision for care and for safety. She will never be financially self-sustaining. She will never be able to manage her own monies. A sheltered workshop will give her a sense of accomplishment and self-worth and help her contribute to society.

It is my hope that once her hip surgeries are completed that these will be the last surgeries that are necessary. Since she has reached her adult size she should not require other musculoskeletal surgeries.

Based on Maggie's age, she can now receive her rehabilitation in an adult setting although due to her intellect she may still do better in a pediatric setting. She would then require rehabilitation at the Rehabilitation Institute in Chicago, or in such centers as D.T. Watson, in Sewickey, Pennsylvania.

Since we don't know the final outcome of Maggie's hip surgery and her ambulatory abilities. There are still many unanswered questions about the overall amount of adaptive equipment she will require. She will never be able to drive a car. It is my hope that she will always be able to independently transfer from her wheelchair to a car. However, someone else would have to put the chair in the car for her. If these transfers become impossible she will then require a van. Since she will be an adult the van will need a lift. It would be best for her to remain seated in the chair. She would therefore need wheelchair locks and tie downs. This obviously then requires a larger garage.

Maggie's therapists could make a home visit to look closely at accessibility. If the plan is for Maggie to remain home throughout her adult life, she would need "an apartment" setting separate from the family, whether such an area can be created within the current home or whether an addition would need to be created could also be assessed.

Equipment such as wheelchairs are estimated to last approximately three years. Likewise at Maggie's age, I would estimate braces to last about three to five years.

Dated this 29th day of June, 1990.

/s/ Ellen L. Kitts MD
ELLEN L. KITTS, M.D.

[Notary Omitted in Printing]

[Dec. 3, 1990]

Vaccine Injury Compensation Program

Patient Claim CT. 90692

Patients Name: Whitecotton, Margaret A.

Case History:

This infant was born on 4/22/75 to a 29 year old gravida 1, mother whose pregnancy was described as normal. Delivery was uneventful with the exception of possible placenta accreta because of the need for manual extraction of the placenta and uterine bleeding. She had Apgars of 8 and 9 and the only significant physical finding at birth was a head circumference of 12½ inches which is below the third percentile. PKU screening test was normal and the hospital course was uneventful and she was discharged after three days.

The subsequent course up until four months of age was unremarkable with the exception of the infant's growth. There are meticulous records of growth measurements from birth onwards. The head circumference was recorded at three weeks, two months, three months, and four months of age and revealed head sizes of 33.5, 35.5, 36.5, and 37 cm. respectively. These are all below the 3rd percentile, and in fact, show a trend of falling off the curve from birth. Subsequent head measurements after four months of age continued the trend throughout childhood. Similarly the birth weight which started at the 10th percentile dropped to almost the 3rd percentile at four months and subsequently was below the 3rd percentile. The length began following off the growth curve at approximately 6 months.

At approximately four months of age the child was given the third DPT immunization and the second oral polio vaccine. Later that same day the mother noted the onset of twitching in the arms. A temperature was reported to

be approximately 100 degrees rectally. The child had three more episodes of arm twitching and at one point was associated with eye blinking. She was taken to the emergency room in Crawfordsville where the examination was reported normal, although the records of that evaluation, in that emergency room, are not available. She was seen the following day by Dr. Baird who observed similar activity. He described a seizure as clonic, fine jerking of the upper extremities that was symmetrical. He stated that the child stopped sucking during this episode and [her] head tilted back slightly. He did not describe the duration of the episode. A possible seizure was observed during the physical examination of the lower extremity. A lumbar puncture was normal although there is a report of possible abnormalities in the immunoglobulins of the CSF. An EEG showed some slowing and disorganization of the background. A brain scan was considered although there was no report of it having been done. No further seizures were observed and the child was discharged on no anticonvulsant medication.

She was admitted in February, 1976, at 10 months of age for a possible seizure disorder; however, the final diagnosis suggested acute airway obstruction. It was noted during that time that the child was hypertonic, microcephalic, and had failure to thrive. The child had several episodes of vomiting. Her examination showed spasticity and the family history of epilepsy in the father was documented. Laboratory evaluation, including TORCH titers and a lumbar puncture were unremarkable. Routine laboratory was unremarkable with the exception of persistent low serum bicarbonate on three different occasions with an elevated anion gap between 16 and 22 mEq/liter. This was not further evaluated.

She subsequently was followed at the Miriam County Cerebral Palsy Clinic where a diagnosis of spastic diplegia was repeatedly mentioned as well as microcephaly. Further, it was determined that she had congenital hip dislocation during these visits.

She was admitted at 20 months of age with a febrile illness and a generalized seizure with the only significant laboratory findings being a CSF pleocytosis of 43 cells which was not explained. She had no apparent infection at that time. She was hospitalized again in 1979 for possible seizures and it was noted that she had had swallowing difficulties since birth. She was hospitalized in October, 1979 for an orthopedic procedure for her hip.

At age 4½ she was given diphtheria and tetanus immunizations, and oral polio by mouth. She was doing well until the following morning when she suddenly developed a seizure and was described as having slight shaking movements in the arms and feet. She was given intramuscular Phenobarbital and intravenous Valium at the Culbert Union Hospital Emergency room at which time she improved. At the time of the emergency room visit her temperature was 102 and it was also noted that the brother had a similar febrile illness at home.

Her subsequent course was characteristic of children with cerebral palsy and mental retardation as documented by several psychometric tests and numerous orthopedic procedures.

The parents' affidavit was reviewed which stated that she developed the above described seizures after her third DPT and second OT immunization and that following this the speed of her head growth slowed, as well as her development. It was alleged that she exhibited post-vaccine encephalopathy resulting in cerebral palsy, mental retardation, and seizures.

Discussion: This 15 year old child has a chronic organic brain syndrome characterized by cerebral palsy, mental retardation, and seizures. In addition, there is a history of congenital hip dislocation, and feeding difficulties from

birth. There is a temporal association with the onset of the first observed seizure following shortly after the third DPT immunization and second oral polio vaccine administration. It is clear from the records that the onset of her microcephaly was at birth and there is no evidence from the records that this was accelerated by or related to the immunization.

As for the legal question of whether this child had a post-immunization encephalopathy, there is no clinical evidence to support an encephalopathy following the immunization such as altered consciousnes, focal or diffuse neurologic signs, or other impairment of brain function aside from the brief seizures that were observed. The abnormal disorganization and slowing of the EEG could possibly support a diagnosis of encephalopathy; however, in the clinical picture of co-existing seizures this is not diagnostic. Furthermore, there are no control studies that have shown an association between immunizations and progressive or chronic neurologic disease.

According to guidelines a residual seizure disorder can be diagnosed if the onset was noted within three days of the immunization and that there were at least two more seizures unaccompanied by a fever greater than 102 degrees within one year. There is no evidence from the record that this child had further seizures during this period.

It is my impression that this child's chronic organic brain syndrome is congenital in nature and not related to immunizations.

/s/ Owen B. Evans
OWEN B. EVANS, M.D.

OBE:jc

CHILDREN'S HEALTH CENTER

410 20th Street, Suite 104
Glenwood Springs, Colorado 81601
Telephone: 945-2571

August 8, 1991

Mr. John Capper
Attorney At Law
c/o Berry, Capper, & Tulley
131 North Green Street
P.O. Box 429
Crawfordsville, Indiana 47933

Re: Margaret Whitecotton
D.O.B.: 4/22/75

Dear Mr. Capper:

At your request I am writing this addenda to my report and testimony, in order to clarify the clinical use and medical definition of the term "microcephaly." I understand that Special Master Baird has requested this additional clarification.

In formulating this response I reviewed the letter of July 23, 1991, which Dr. Owens submitted to Ms. Hidalgo. This matter seems to be boiling down to two core questions: 1) Did Margaret Whitecotton have true microcephaly from birth? 2) If she did have true microcephaly, did that condition predispose her to seizures and profound mental retardation?

In several respects, I find myself in agreement with Dr. Owens' letter of July 23. We both agree on the authoritative nature of Nelson's *Textbook of Pediatrics (13th Edition)*. I also agree with his statistical explanation of two standard deviations. However, as I understood the Court's request, Special Master Baird was asking for the

Government's authoritative source in defining true microcephaly as two standard deviations from the mean. In fact, the Government produced a treatise defining two standard deviations, and in so doing, relies on the Nelson textbook.

One only has to consult p. 1303 of Nelson's textbook wherein there is a point blank definition of microcephaly: "Head size is *more than three standard deviations* below the normal mean." Margaret's head circumference, up to age of six months, was not three standard deviations from the mean, let alone greater than three standard deviations. As I testified, one must conclude that she was a small child with a small head, not microcephalic, and her short stature, by itself could never have portended the dire outcome which she suffered.

The se[c]ond core question which I have raised above becomes academic since both the Government and the Petitioner accept the authoritative nature of the Nelson textbook. For the sake of argument, the Court should understand, that clinical research in child neurology has very much changed the way we look at children with small heads. During my training we were taught that over 90% of these children would be retarded because of poor brain growth. Since then there have been several studies that implore us to re-evaluate that conclusion.

One such article appeared in *Pediatrics,* Vol. 59, No. 2, February, 1977, pp. 262-265: Sells, C.J., "Microcephaly in a Normal School Population." In that study, of 1006 students between the age of 5 and 18 years, 19 (1.6%) had a head circumference which was two or more standard deviations below the mean. When these 19 children were compared with normocephalic controls, as far as I.Q., no significant differences were found. None of these children were mentally retarded. This prompted Sells to conclude that "a small brain, as reflected by a head circumference of between -2 and -3 SD does not in itself

produce mental retardation" (Ibid. p. 264). It is this type of research which correctly led Nelson to his definition of microcephaly.

Finally, it is clear that Margaret suffers from a residual seizure disorder, her seizures beginning within 24 hours of the third DPT injection. This telling proximity is highlighted by the testimony of Dr. Kitts, and the medical record, which note normal development up to 4 months of age, and the subsequent deteriorating course.

I hope this additional information is helpful to the Court.

Sincerely,

/s/ Gerald E. Slater
GERALD E. SLATER M.D.
Pediatric Neurology

[Attachments Lodged with the Court]

IN THE UNITED STATES CLAIMS COURT

No. 90-692V

MARGARET WHITECOTTON, BY HER NEXT FRIENDS, KAY WHITECOTTON AND MICHAEL WHITECOTTON, PETITIONERS

v.

SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT

TESTIMONY OF KAY WHITECOTTON FROM JUNE 4, 1991 HEARING

* * * *

WHITECOTTON—DIRECT

[11] Q What doctor did you see at that time, ma'am?
A I saw two dotcors, Sam Benjamin and Jack Foltz.
Q And what is their designation, family physician or OB-Gyn?
A They are OB-Gyn.
Q Did you begin a normal prenatal course with them?
A I sure did.
Q Approximately how many times did you see them over that period of time?
A I saw them at least 15 times.
Q During the time that you saw Dr. Foltz and Dr. Benjamin what was your health?
A I was in excellent health.
Q Prior to your becoming pregnant how was your health?
A Excellent. I did not smoke. If I drank it was a glass of wine just occasionally.

Q How about during the pregnancy, ma'am? Any smoking or drinking?
A No smoking. No drinking at all. I took vitamins. I did everything I was supposed to do. I ate well, exercised.
Q During the time that you saw Dr. Foltz was he reporting normal progress in the pregnancy?
A Yes, he was.
[12] Q Would you characterize your prenatal period as being uneventful and normal as far as you were concerned?
A It was pleasant.
Q When was Maggie born, ma'am?
A Maggie was born April 22, 1975, at 3:28 in the afternoon.
Q Can you describe your labor?
A I went in somewhere around 7:00 in the morning and about eight hours of labor or less.
Q Would you characterize your labor as normal labor?
A Normal labor.
Q Did you have a fetal heart monitor on during labor?
A Yes, I did the entire time until I went into delivery.
Q Were you able to notice while you had the fetal heart monitor on whether or not there was a good heartbeat and no stress on the child?
A They explained it to me because I had lots of questions. I am a person that questions everything that happens to me healthwise.
Q What did you note?
A They said that it was perfectly normal and if there was any change in it I would immediately know. There was no change in it. She was doing well.
[13] Q What about the heartbeat of the child during that time?
A That was the heartbeat of the child. That is what I was watching.

Q At the time of birth were there any problems with the birth?

A Maggie was fine. She came out crying. I immediately got to see her.

Q I know the record reflects this, but I did note Apgar scores at that time?

A Yes, her Apgars were eight and nine.

Q And what perception did you have when the doctors took a look at Maggie at birth?

A My OB-Gyn said I had a beautiful, healthy, normal baby girl. Shortly after that our family practitioner came in, and he concluded the same.

Q Were you released from the hospital then a few days later?

A I was released in three days, along with my daughter.

Q After the child was born and while you were still at the hospital did the child go into any distress, put into ICU, under any type of need for special equipment or any special needs while she was in the hospital?

A None whatsoever. She visited me according to [14] their usual schedule, and I fed her.

Q Upon release from the hospital did you see a doctor or family physician, someone to care for the child after your release?

A Yes, I saw our family practitioner in three weeks and then at regular schedule.

Q Who was that ma'am?

A That was Wesley Shannon.

Q As indicated in the record, you apparently saw Dr. Shannon at intervals of three weeks, six weeks, two months and three months. Is that correct?

A That's correct.

Q During the time that you saw the doctor did he report anything unusual about the child, or were things going well up through the vaccine of August 18, 1975?

A He assured me that she was doing great.

Q During that time, ma'am, and I am talking now about the time frame between birth and August 18, 1975, if I may, can you describe the child and what you observed about the child as the child was growing up?

A Maggie was a fun baby. She was very enjoyable. I held her often. I spoiled her. She was very healthy, very normal. I was never concerned about her.

Q How about her milestones during that period of time? Did you note her milestones during that time?

[15] A She developed very rapidly. She met all the milestones that my baby book said she should be doing. In fact, some of them were early.

Q Was she able to smile at you, roll over?

A Oh, she smiled, she rolled over, she played with her feet, she put her hands together, she giggled out loud, she sat up with support on her back, she ate well.

Q Mrs. Whitecotton, did you bring this morning photographs that were taken of the child during that time period we are talking about?

A Yes, I did.

Q I will show what has been marked for purposes of identification as Petitioners' Exhibits O-1 through O-6 and ask if you could identify each of those. As you indicate the photograph, indicate the exhibit number O-1, O-2 or whatever and indicate who that is a picture and the approximate time that picture was taken.

A This is O-1. It was taken April 25, three days after Maggie was born, the day we arrived home from the hospital.

The next one is—I need a longer arm here—O-8.

Q It should be O-2. They are in order.

A Shall I get my glasses?

Q If you have them here go ahead.

[16] A This is the same day. I mean—I am sorry—April 26.

Q Of 1975?

A 1975.

Q Where did you get these pictures?

A I got these pictures from her baby album.

Q Go ahead to your next picture.

A This is O-3 dated April 26. These were taken by her grandmother. The next one is early August, pre-DPT, and it is O-4. She is having a little cry there.

Q How do you know that that was taken at that time?

A It was posted in my baby book.

Q Go ahead, ma'am.

A The next one is O-5, early August, 1975, and she is on the sofa sitting propped up. The next is O-6, early August, 1975, the same thing.

Q Do those photographs fairly and accurately depict your daughter, Maggie, during that period of time you have referenced?

A I'm sorry?

Q Do these photographs fairly and accurately depict Maggie during that period of time we have referenced?

A Most certainly.

MR. CAPPER: I guess they are already moved into evidence.

* * * *

[18] Q On August 18, 1975, if I could call that to your attention, do you remember and recall Maggie and recall her condition prior to the vaccination that day?

A She was well when I took her to the doctor. It was her normal check-up.

Q Did Dr. Shannon administer the DPT shot at that time on August 18?

A Yes, he had administered all of them himself.

Q Approximately what time of day was that, if you recall?

A It was shortly after noon.

Q After she received the shot did you proceed home that day, or what did you do?

A I do not recollect that, but I would assume that I did go home.

Q Did anything unusual occur after the shot that day?

A Not until around 6:00 that evening when we were out for our walk. She appeared to be a little fussy, so we walked outside. I felt her move first, and she was going—this is the best way to describe it.

Q For the record, Mrs. Whitecotton, you are describing flinching or jerking of the upper extremities and blinking of the eyes. Is that correct?

A Right.

[19] Q How many times did that type of movement occur, ma'am?

A It occurred three or four times before I realized that something was drastically wrong. Then I went to the ER at Crawfordsville.

Q When you say occurred two or three times, was that at different intervals?

A Twenty to 30 minutes apart.

Q Twenty to 30 minutes apart?

A Yes.

Q This jerking of the upper arms and blinking of the eyes as you have described occurred how many times then on August 18, 1975?

A Three or four.

Q Did the child have a fever at that time, as far as you know?

A No. I had taken her temperature myself, and it was just around 100. At the ER they also took it rectally, and it was around 100.

Q Did the child sleep through the night?

A She did sleep through the night. She slept well, and I checked her frequently to make sure that she was doing well.

* * * *

[25] A May I revert back to one situation at Riley?

Q I do not know what you are referring to.

A When we were in the ward and it was a concern of mine when she projectile vomited for the first time across the room. I didn't realize what it was. She had never done that before.

Q And that was at Riley Hospital?
A That was at Riley.
THE COURT: How is Riley spelled?
THE WITNESS: R-I-L-E-Y.
BY MR. CAPPER:
Q The records that are part of the exhibits here, Mrs. Whitecotton, show at the top Marion County General Hospital on one side and Indiana University Hospitals on the other. Is Riley Hospital part of the Indiana University hospital system?
A That's correct. That's correct.
Q So when we refer to Riley Hospital we are talking about those record that may show Marion County General Hospital/Indiana University Hospitals, correct?
A That's right.
Q Did you note then as time went along after August 18, 1975, any change in Maggie with regard to her health and with regard to her development?
[26] A Healthwise the one thing that stands out in my mind most of all is the fact that projectile vomiting became a very frequent event in our home.
Q How about her development?
A Developmentally the milestone that she had so easily reached prior to the DPT shot became scattered, and sometimes she just, you know—in fact, at one point in time before the shot she was raising her little feet up in front of her hands. She no longer did that.
Q Any other specifics like that or things that she was not marking or making in terms of milestones or observations you made, if any?
A Well, I don't know how to explain it, but slouchy. She was so erect before. She just became slouchy, for a better term.
Q I will now show you what has been marked as Petitioner's Exhibits O-7, O-8 and O-9 and ask if you can identify those for the record, please.
A Yes. O-7 is Maggie at one year.

Q And this is subsequent to August 18, 1975?
A Right. O-8 is Februray, 1976, and O-9 is Christmas of 1975.
Q And again, you got those photographs from her baby book or baby album?
A Right.

* * * *

[29] BY MR. CAPPER:

Q As time has gone along here since August 18, 1975, can you describe Maggie's condition, her health and her progress up through the present time?
A I am sorry, John.
Q Can you describe Maggie's health and Maggie's progress since August 18, 1975, to the present generally?
A Well, generally she is moderately to severely retarded. Her progress is very slow.
Q Is she able to communicate, Mrs. Whitecotton?
A To her family.
Q You say to your family. I do not know what that means?
A She is non-verbal.
Q Non-verbal? Okay. Is it required that she have someone with her in attendant care at all times?
A Yes.
Q Does the videotape that we submitted as an exhibit fairly and accurately depict how Maggie is today in terms of her ability to move about and ambulate, among other things?
A Yes. She is not able to even be helpful and ambulatory.
Q Did you begin noticing anything about the child with regards to her hands or legs or anything after the August 18, 1975, vaccination?
[30] A I noticed that she no longer pulled her little legs up to play with them like she did before. She was frail. She didn't eat as well. She was able to mechanically eat the food. I mean, that wasn't the problem. Her

problem was the fact that she would get a lot of mucus and then projectile vomit.

We had a very difficult time finding people to take care of her because she would stress them out so much because she would cry constantly with them. She was very fretful—I guess that is the best word—from that moment.

Q There has been some indication, I believe it is F-6 or something in the exhibits, that you made mention at some point in time to the doctor, and I do not think the doctor observed this, but you made mention to the doctor at some point that you may have noticed on one occasion or another leg jerking or something in the past. What did you observe, and when did you observe that effect?

A She was napping when I noted it. There would just be a little jerk of her leg. It wouldn't wake her up. I did not think anything about it at all other than a normal childhood behavior.

* * * *

[35] Q And at that time did they measure Maggie's length and height and head circumference?

A As they did my son; as they do every child.

Q And they never said anything to you about her head being unusually small?

A No.

Q Did you ever observe Maggie having swallowing difficulties before she was four months old?

A No.

Q Are you aware that there is a medical record that says in the patient's history that she had swallowing difficulties since birth?

A I believe that is Dr. Hwang, is it not?

MS. HIDALGO: Yes.

Let me direct the attention of the Court. That is Exhibit H-12, Page 3.

WHITECOTTON—CROSS

BY MS. HIDALGO:

Q Did you ever have discussions with Dr. Hwang?

A Dr. Hwang was her pediatrician, yes.

* * * *

[41] Q So you noticed projectile vomiting the first day that she was hospitalized or the second day?

A Well, I don't know that either. I can't recollect that.

Q Did you see her projectile vomiting only once?

A I was holding her. That was the only time I saw her do it at Riley. I asked the nurse. I remember what I said. I remember making a face. I remember seeing it on the floor. I said what is this crap? That is the words I used. It was like an oil slick. You could just push it around the room. It was just awful stuff mixed with formula. I had never seen it before.

Q When you say it was like oil, was it like mucus?

A It was mucus and milk. It was horrible stuff.

Q You said you spoke with a nurse. Did you talk to a doctor about this also?

A I told the nurse, I said please tell the doctor about this. I had not seen her medical records until this year, and I see nothing in the records that tells me that the nurse told the doctor.

* * * *

TESTIMONY OF ELLEN KITTS, M.D.
FROM JUNE 4, 1991 HEARING

KITTS—DIRECT

* * * *

[60] Q Dr. Kitts, I am going to show you some photographs that have been previously introduced through Maggie's mother. I will show you these in sequence.

I show you what has been marked for purposes of identification as Petitioners' Exhibit O-1 through O-6. I would like for you to just look at those. I will tell you for the record that those have been identified as Maggie Whitecotton pre third DPT vaccination from early childhood to late July or early August of 1975. Could you please review those photographs?

A In my practice I frequently am asked when does something happen, when did a child develop cerebral palsy or when did they have their stroke. In my practice I routinely [61] ask patients to bring photographs to me because sometimes I can get information from that.

The first one that I have marked O-1 is dated April 25, 1975. This is a newborn infant. The hands are held close to the face so that her elbows are flexed, but the fingers are open. The hands are relaxed.

Q What does that tell you, doctor?

A This is normal posture for a newborn infant.

Q Would that indicate cerebral palsy or brain damage at that stage?

A No, I see no sign of any brain dysfunction in this picture.

Q What about the next one, O-2?

A The next one is O-2. Again it is a newborn infant being held. Again this looks like a normal newborn infant. The hand is relaxed. It is open. The fingers are open. The arms are again held close to the face. This is a picture of a normal newborn.

Q The next photograph?

A This is O-3. Again this is a newborn. This time the shoulders have been flexed so that the hands are extended up above the head.

Q What does that tell you, doctor?

A Children with cerebral palsy do not have the capabilities of being this relaxed and having the hands in [62] that position. Children with cerebral palsy have a lot of difficulty getting their shoulders to move so that their hands are always down rather than being relaxed and up.

The next one is O-4. In O-4 Maggie is obviously crying and very unhappy. In this position again her overall body is overall relaxed. Children with cerebral palsy, the more emotionally upset they become the stiffer they become, the more their arms straighten, the more their hands fist, the more their thumbs tend to go into the palm. Again, even though she is obviously really upset her hands are open and relaxed. Her thumbs are widely out of the palms. The muscles of facial expression are working well. This again is a normal picture.

Q Do you have O-5 there?

A Yes. In O-5 she is prop sitting supported by a pillow. Again, this is a very normal for this aged child. The legs are relaxed. They are bent a little bit. The feet are in a normal position. They are not pointing toe down. The arms are relaxed. The hands are open. The fingers are relaxed. Again, this is a very normal picture.

The last one I have is O-6. In this one she is being held supported, but she has excellent head control. She has her hands together in midline. She is playing with her fingers. Her hands are open. Again, this is a nice developmental picture, and everything looks normal. That is [63] four months of age.

Q Doctor, what would you expect if you had a child in those pictures? If you were to look at those pictures now and had a child that the doctor claimed she had cerebral palsy what would you expect to see in those pictures?

A I would expect to see either too much stiffness or too much looseness. For the children that are too loose and are floppy they don't have head control. They don't have the ability to hold their arms against gravity, so they can't really flex them, which she has done nicely. You may see side to side differences or changes in the face. Again, none of those changes are present.

In a child that has too much stiffness the hands are always fisted, and instead of just being a normal fist usually the thumb is inside the fist, which is called cortical thumb, and again is a sign of brain damage. The more angry they become the stiffer they become and the more the fist tightens. Often times the more the elbows straighten they are not able to get their hands or arms up above their head.

Children with too much stiffness tend to have their legs go straight out. They are not able to bend their knees. Their toes are pointing straight ahead. They are not able to relax their ankles and bring their feet up. In these pictures I don't see any signs of any of those [64] problems.

Q Do you see any signs of brain damage?

A No.

Q Doctor, I want you to look at some photographs that have also been identified by the mother. They are marked for identification purposes as Exhibits O-7, O-8 and O-9.

I will tell you again that those are photographs that have been identified by the mother as Maggie Whitecotton, the Petitioner in this case. I believe the dates are indicated on the back, but those were taken after the third DPT shot of August 18, 1975.

Will you take a look at those and identify the photograph as you go through those, please?

THE COURT: Start with O-9 if you will because I think that is the oldest. I think they are in reverse order.

MR. CAPPER: Okay.

THE COURT: O-9 was Christmas of 1975.

MR. CAPPER: That is right.

THE WITNESS: In O-9 Maggie is being held by her mother, and at this time mother is giving her more support than she was in previous pictures.

* * * *

[68] Q And the delivery was uneventful?

A That's correct.

Q She had Apgar scores of eight and nine, correct?

A That's correct.

Q What about Apgar scores of eight and nine? As you look at those initial pictures, O-1 through O-6, does that correlate?

A Apgar scores describe the amount of difficulty the child is having with the delivery. If it is a real difficult delivery on the child and the child is being really stressed then the Apgar scores will be low.

Apgar scores above seven are considered normal and are not associated with any sort of neurologic impairment or neurologic damage. Apgar scores below seven, the children are at high risk to have had neurologic damage because of the stress of the delivery. These Apgar scores are completely normal.

Q So it would be your opinion, based upon a reasonable degree of medical certainty, that there was no neurological damage at birth based upon Apgar scores and the other medical information you have?

A That's correct.

* * * *

[74] Q Having reviewed the medical records information, having looked at the pictures pre third DPT shot, having heard the testimony of Maggie's mother with regard to the child's condition and her milestones and based upon your experience and training do you have an opinion as to whether or not Maggie had suffered from cerebral palsy or brain damage prior to August 18, 1975, based upon a reasonable degree of medical certainty?

A In the history that I have, in the records that I have and in looking at these photographs, which is my only connection with Maggie at this early an age, I see no sign of any brain damage or no sign of any cerebral palsy from early August of 1975 and prior to that.

From birth through early August of 1975 the medical records that I have and the pictures that I have are all of a normal infant without any signs of cerebral palsy, without any signs of brain damage.

THE COURT: Let me just interrupt here for a second. I am not sure her answer was responsive to your question, and I want to make sure for the record that I understand what it is she is saying.

He asked you if you had an opinion to a reasonable [75] degree of medical certainty as to whether or not there was brain damage, I believe, prior to August 18, 1975. Do you have such an opinion?

THE WITNESS: I do have.

THE COURT: And what is you opinion?

THE WITNESS: There is no brain damage prior to August of 1975.

THE COURT: Thank you.

BY MR. CAPPER:

Q Doctor, you have had a chance to review the medical records as they confirm and relate seizures that were observed by the mother the day of the vaccination, which would have been August 18, 1975, have you not?

A Yes.

Q And also you have had a chance and an occasion to review the records and report of Dr. Baird confirming additional seizures the following day of August 19, 1975, have you not?

A Yes.

Q The following day meaning the day after the vaccination? Is that correct?

A Correct.

* * * *

TESTIMONY OF GERALD E. SLATER, M.D.
FROM JUNE 4, 1991 HEARING

SLATER—DIRECT

* * * *

[157] Q What conclusions can you draw from those photographs?

A I don't draw the conclusions that Dr. Kitts does. To me they are not all that helpful. What I do see is a persistence of cortical thumbs subsequent to four months, which I don't see prior to three to four months.

Cortical thumbs are a fisting with the thumbs in palm. It is an abnormal motor tract sign. That is all it speaks to. It is called cortical thumbs. At birth if it is intermittent it is normal. If it is persistent it is always abnormal. At birth you overlook a child who shows cortical thumbs intermittently. You never overlook it if it is persistent.

That is all I see from this. I don't know about obliquitonic neck reflex from a single picture.

Q You will leave that to Dr. Kitts?

A I am not going to testify to that.

Q Doctor, you have also reviewed the records of Riley Hospital upon Maggie being admitted to Riley Hospital in August of 1975—

A I have.

* * * *

SLATER—CROSS

[179] BY MS. HIDALGO:

Q So if the child suffers a trauma which will result in microcephaly, when does one document the microcephaly after the trauma?

A Good question. It is hard to say. Depending on the severity of the trauma, I would think it would be from several weeks to several months. If it is a minor trauma it may take several months. A severe trauma it is going to take a week or two.

Q So if the medical records demonstrate that the child deviated on the 20th of August does that not tell you that the trauma occurred sometime a week or more before that?

A Something was clearly happening to the child [180] before. Whether it was clear-cut secondary microcephaly depends on whether we are going to go with two or three standard deviations.

You are right. Something is clearly happening between three months and four months.

Q So something clearly happened before the DPT was administered?

A Something is happening if you believe two standard deviations. If you go with Nelson's three standard deviations, then nothing happened until six to eight months.

Q Regardless of whose deviation we are taking there is a change? She is no longer on the second percentile?

A That's true. She is slightly below the second percentile at four months.

Q You said in your letter to Mr. Capper dated March 24, which is Exhibit L, at the bottom you say—

A At the bottom of what page?

Q I am sorry, the first page. You say, "She then suffered impaired brain growth, and her head circumference fell off its normal curve. This is termed secondary microcephaly, and it implies a postpartum injury to the brain at or around three months of age."

A Right.

TESTIMONY OF OWEN B. EVANS, M.D.
FROM JUNE 4, 1991 HEARING

EVANS—DIRECT

* * * *

[206] Q What conclusions have you drawn from your review of the Petition, affidavits, medical records and the additional materials?

A It is my opinion that Margaret Whitecotton had a congenital organic brain syndrome that was characterized by microcephaly, mental retardation and cerebral palsy with epilepsy and that this was the result of prenatal factors.

MR. CAPPER: I am sorry. I did not hear that, doctor, the last part.

THE WITNESS: It is a result of prenatal factors.

MR. CAPPER: Okay.

BY MS. HIDALGO:

Q You indicate in your letter to me that you consider Margaret microcephalic. Is that correct?

A That's correct.

Q When, in your opinion, did she become microcephalic?

A She was at the second percentile at birth, which is at two standard deviations below the mean. That definition is microcephaly.

Q So your definition is at the two percentile or below?

[207] A At two standard deviations or below. Two standard deviations is approximately 97.5 or 97.6 percentile, or if you go to the other end it is going to be approximately from the 2.3 to the 2.5 percentile. She was at the second percentile, which would be at or below the two standard deviations.

Q Is it your opinion that Margaret was microcephalic before receiving the DPT shot on August 18, 1975?

A Yes.

Q What is the etiological origin of Margaret's serious neurological deficiency?

A This would come in the category of primary microcephaly. There are many factors which can cause that. Some are familial, some are diagnosed intrauterine insults, and then there is a large proportion which are just unknown.

Q What do you mean by chronic organic brain syndrome?

A This is a non-progressive developmental disorder of the brain. It is characterized by impairments of cognition, motor activities, learning and often associated with epilepsy or similar types of phenomenon.

Q Did you say it was non-progressive or progressive?

A Non-progressive.

Q What do you mean by that?

A In that [t]he deficits are fixed. That is, the [208] child's intellectual impairments and motor impairments and other things do not deteriorate with time. The child is born with a fixed deficit.

Q What evidence in the medical records supports this medical opinion of yours?

A The major evidence is the small head. I think almost all authorities would agree that a child that is microcephalic is inherently at risk of having severe developmental disorders such as cerebral palsy and mental retardation.

The other points in the record are the history of lifelong feeding difficulties, the history of seizures and the subsequent diagnosis of cerebral palsy and mental retardation.

Q Can you identify where in the medical record there is a reference to feeding difficulties?

A Yes, if you will give me a moment here. This would be under I think it is Exhibit H-11. No, I am sorry, H-12, Montgomery County Culver Union Hospital of 8-29-79. It is located on my Page 3, which I assume is the discharge summary. It says past medical history—past history, medical.

MR. CAPPER: What page is he on?

THE COURT: Page 3.

MS. HIDALGO: Three.

[209] MR. CAPPER: Just for clarification, is that Dr. Hwang's history?

THE WITNESS: It is Dr. D.S. Hwang, H-W-A-N-G.

MR. CAPPER: That is Hwang in Crawfordsville.

THE COURT: Go ahead.

BY MS. HIDALGO:

Q Why is that significant, Dr. Evans?

A Because children with cerebral palsy and mental retardation often present with feeding difficulties because of the poor coordination of all their musculature, including that of sucking and swallowing.

Q Is there a relation between microcephaly and mental retardation?

A Yes, there is a very close relationship. It varies on the author that you read, but for example, Menke in his textbook says virtually 100 percent of children with microcephaly have mental retardation. That is probably a little bit too extreme. Most of them would say upwards of 90 percent or perhaps 95 percent will have microcephaly.

Looking at it the other way around, if you look at the microcephalics and try to find out how many of those will eventually have normal intelligence it is only 7.5 percent of those. Most of those are the familial types; that is, the parents had microcephaly as well, and the child inherited that as an autosomal dominant trait.

[210] Q Is there a relation between microcephaly and cerebral palsy?

A Very much so. The children who are microcephalic have evidence of brain destruction or brain undergrowth. As a result of that they have impaired motor functions so that cerebral palsy is found in a large percentage of children with microcephaly.

Q A child who is born with microcephaly, is it common for them not to exhibit any sort of cerebral palsy or neurological disorder in the first few months?

A That is often the case. A child's abilities are not noted to be lacking until they are what is called developmentally recruited. For example, you are not going to know if a child is going to walk or not until after anywhere from 12 to 18 months of age because you don't expect a child at two months or three months to have normally the ability to walk.

There is one study that said about 36 percent of children thought to be neurologically normal at four months of age turned out to be neurologically abnormal. That doesn't mean we are not good examiners. It just means that many of the signs and symptoms that appear later in development—excuse me; many of the abilities that appear later in development—are just not detectible early on.

* * * *

[213] Q What is that opinion?

A My opinion is that she did have seizures to answer your first question, and the second question, my opinion is that these seizures were related to her chronic organic brain syndrome or chronic encephalopathy and not related to her DST immunization.

Q Do you hold that opinion to a reasonable degree of medical certainty?

A Yes.

Q What evidence is there in the record to support your opinion?

A My primary evidence is the clinical picture of her multitude of developmental disabilities, which include the cerebral palsy, the mental retardation, the microcephaly. In that group of patients epilepsy is an extremely common event. Up to 33 percent of them will have seizures along with their other developmental disorders.

I do not see any evidence that the child suffered an encephalitic or encephalopathy at the time of her immunization to think that she had an acute neurologic deficit with it in which the seizures would be a symptom

of that, so it is my opinion that these seizures were independent of the DPT immunization.

* * * *

[219] BY MS. HIDALGO:

Q Dr. Evans, of these three charts do they all reflect the child being at the two percentile in the first two months then below the second percentile after the third month and getting lower and lower from the second percentile thereafter?

A That is correct.

Q Is that consistent with a child with primary microcephaly?

A That is correct.

Q Is that consistent with a child who has chronic organic brain syndrome?

A It is one of the signs of chronic organic brain syndrome. Not necessarily will every child with chronic organic brain syndrome have microcephaly. A small percentage of them won't. Some children with chronic organic brain syndromes will have a normal head size.

Most children, the vast majority of children, with microcephaly will have mental retardation and these other problems.

Q With respect to the seizures that Margaret sustained on August 18, 1975, what, if anything, do they indicate?

A In my opinion it indicates another symptoms of her chronic encephalopathy. In other words, they are a symptom [220] as is cerebral palsy, as is mental retardation.

Q In your opinion did the seizures percipitate the microcephaly?

A No.

Q Have you drawn any conclusions about the temporal relationship between the administration of the vaccine and the child's seizures?

A It is my opinion that those were coincidental and not causally related.

Q Is there any evidence in the record showing that the episode of seizures on August 18 and 19, 1975, caused the problems identified in Margaret's first year of life, namely mental retardation and cerebral palsy?

A No, there is none at all.

Q Is it your opinion that the seizures of August, 1975, had little, if any, effect on Margaret's neurological deficiencies?

A No, it is my opinion it does not. The seizures that were described in the record were brief. They involved usually an extremity, or they involved staring and unresponsiveness. To my knowledge and in my experience, that does not cause brain damage.

The only way that one can ascribe brain damage from seizures is one, if it is very prolonged with generalized tonoclonic activity or a grand mal seizure that [221] impairs respirations to the point that the brain does not get sufficient oxygen. That certainly is not described in the record.

Another theoretic possibility is repeated seizures over many days, months or years that might impair the metabolic activities of the brain and cause some brain function deterioration.

In large studies, for example, the perinatal study with the NIH in which they looked at children who had grand mal seizures and repeatedly so with fevers, they did not have any differences in their ultimate IQ or other neurologic deficits. Even in the worst case seizure scenario, brief occasional seizures do not appear to have any adverse affect on the brain.

Q In your opinion, were those seizures consistent with the pre-existing microcephaly?

A Yes, they are.

Q Excuse me?

A Yes.

THE COURT: Did you say you guess, doctor?

THE WITNESS: No, I said yes.

THE COURT: Excuse me.

BY MS. HIDALGO:

Q Do you hold that opinion with a reasonable degree of medical certainty?

[222] A Yes.

Q What other neurological disorders are typically associated with microcephaly?

A The major ones are those of cognition, which usually relates to mental retardation or learning disabilities, and the other one is motor impairment, which usually is characterized by in the subtlest form clumsiness or incoordination and in the most serious forms as cerebral palsy. Many children also have behavioral disorders associated with it as well.

Q Assuming that the seizures resulted from the August 18, 1975, DPT vaccination, is there any evidence to indicate that those seizures aggravated Margaret's pre-existing microcephaly?

A No, there is no evidence. I will go back to my previous answer that the seizures as described, in my experience and reading, would not in any way cause significant brain injury or anything else. Further, there was no history by description coincidentally with those seizures that the child was suffering from an encephalitis or acute encephalopathy.

There was one mention in the record that the child had been seen the day before in Crawfordsville or whatever, and the examination was stated to be normal. I believe in the examination when she was hospitalized for the seizures [223] there was no indication that the child had encephalitis or altered consciousness so that the seizures were not of a type that would cause brain injury, and they were not a symptom of an acute encephalitis or encephalopathy that would cause brain injury.

Q Have you seen or treated other patients with chronic organic brain syndrome?

A Yes, I have.

Q Have those children been microcephalic?

A Many of them have, yes.

Q Have they exhibited signs and symptoms consistent with Margaret's?

A Yes, and in every way.

Q About how many children would you say you have seen with chronic organic brain syndrome?

A If one includes all children with cerebral palsy and mental retardation together it would probably number in the hundreds, if not more, at our general pediatric neurological clinic, in which we receive the majority of referrals throughout the entire State of Mississippi, and also at the crippled children's clinic, which receives a good portion of referrals, and at our children's rehabilitation center, in which many children with cerebral palsy and similar problems are admitted.

* * * *

[226] BY MS. HIDALGO:

Q Are children with microcephaly more likely to have seizures resulting from a febrile illness rather than an afebrile illness?

A Yes.

Q What I am actually getting at is do fevers often induce seizures in microcephalic children? Is that common?

A Fever induces or are more likely to induce seizures in any child who has epilepsy or is seizure prone. I wouldn't necessarily say it is more likely in a microcephalic child than another child who has epilepsy or is seizure prone.

Q On what do you base your opinion that the seizures of August 19, 1975, did not aggravate Margaret's preexisting chronic organic brain abnormality?

A Again, for two reasons. One, the seizures as described in the medical record are not those that are associated with brain injury. Secondly, there was no other signs of an acute encephalitis in which the seizures would simply have been a symptom of a more serious brain injury.

I see nothing in the record that would indicate that the seizures in and of themselves caused any brain damage.

Q Is there any evidence that the seizures accelerated her cerebral palsy?

[227] A No, there is no evidence for that.

Q How would you compare Margaret's course with the normal course of a microcephalic child who had not had any DPT complications?

A I would say all things considered they would be very typical for any other child that had cerebral palsy, microcephaly, mental retardation and epilepsy. They would be identical.

Q Do you have any opinion as to why a chronic brain abnormality was not raised as a possible etiology during Margaret's hospitalization?

A In my opinion it was raised because they identified the child as being microcephalic. That was clearly stated, and I think for good reason. The child was clearly microcephalic by anybody's definition at the fourth month. That certainly couldn't have been induced by the DPT that was given that very day.

The second reason is that I think the child came in hand with the diagnosis of DPT related seizures. I think that that was a general assumption at the time.

Finally, I don't think that the child—as I mentioned earlier, the neurological examination—with her degree of cerebral palsy and mental retardation would necessarily been detectible at four months.

Q In your practice have you encountered a child with [228] cerebral palsy secondary to a chronic brain abnormality which has been as serious as Margaret's?

A Much more serious in many cases.

Q About how many cases?

A With the typical picture of microcephaly, cerebral palsy, mental retardation and epilepsy, with all those things combined there have been at the minimum dozens of patients very similar or more severe.

Q Have you had an opportunity to review the medical opinions of Dr. Slater and Dr. Kitts?

A Yes, I have.

Q Do you have any comments?

A Yes, if you can give me a moment to pull those up. I think this is Dr. Slater's, and I think it has been marked Exhibit L and N. I think L is his statement. I think N is his CV. Do you all have that?

On the third paragraph of the first page of Dr. Slater's comments it says, "Her head circumference grew exactly at the second percentile through the first three months of life. At four months of age her head circumference was for the first time off the growth chart and clearly below the second percentile."

* * * *

EVANS—CROSS

* * * *

[237] Q Do you believe there is a causal relationship between the pertussis vaccine and a person having an adverse reaction?

A Yes, I think there are adverse reactions to a pertussis vaccine.

Q Is that even though you indicate in your report that there are no control studies that have shown as association between immunizations and progressive or chronic neurologic disease?

A I am sorry. What is the question there, Mr. Capper?

Q The last page of your letter, the third paragraph from the bottom, your last sentence says, "Furthermore, there are no control studies that have shown an association between immunizations and progressive or chronic neurological disease." Do you still believe that?

A Yes.

Q So it is your opinion then that really there are no studies that shown the association between these DPT shots and chronic neurological disease?

A Well, there are studies that have shown it, and there are studies that have not it. There are studies that [238] reviewed studies that have not shown it.

Q I am asking you, though. Your statement is—

A It is my opinion that there are no control studies that well document association between immunization and progressive or chronic neurologic disease.

Q And is that your feeling also? I mean, you are saying the studies. Is that your feeling also?

A That is my opinion in reviewing the studies, yes.

Q Do you find that to be, applying in the face of our purpose here today, to believe there are no control studies associated between immunizations and chronological neurological disease and the fact that Congress has passed this Act believing that there is that relationship?

A I am not here to debate what Congress says. I mean—

Q But on that basis, if they are assuming that fact, that connection, do you find that to put some suspect in your opinions—

MS. HIDALGO: Objection.

THE COURT: Allow him to finish the question.

* * * *

[240] Q And if you believe there are no studies that show any connection and we are here in a program that says there is a connection, does that not taint your testimony then before this Court—

A Counsel, I don't think it taints my testimony at all.

Q Just a second. Just a second. —as to whether or not there is a causal connection?

A I am not sure that Congress established a cause. Congress established a program in which—

Q That was not my question.

THE COURT: Allow the witness to answer the question.

THE WITNESS: I don't think the vaccine law states that there is a causal effect. It just sets up a compensation mechanism for children who have had various and sundry events occur in relationship with DPT. I don't think that it states that it does cause it.

My opinion is my opinion, and that is I do not think it causes it, and I don't think it applies in the face of anything. That is my opinion.

BY MR. CAPPER:

Q But is it not a fact that when you have a predisposed opinion that when you look at facts—medical [241] records—then you can look more favorably to those in making your opinion having that predisposition?

A Well, that assumes my predisposition was made prior to reviewing the records. My feelings are cumulative over reviewing many documents that have come out.

For example, our own Child Neurology Society had a group of concerned people and experts, and their opinion was published just this April. Another opinion came out in the medical literature in the Journal of Pediatrics came out in March. Those go into my thinking about this. I believe I was assigned this case sometime late last fall.

Q But you still believe there is no connection, do you not, doctor?

A Yes. After reviewing all the material available and the literature it is my opinion at this point.

Q No, I am talking about your opinions themselves of the causal connection.

A Yes, and my opinion is subject to change if another articles comes out that shows more scientific validity than—

Q But I am saying right now.

A Right now that is true.

THE COURT: He has stated clearly what his opinion his, [*sic*] counsel.

MR. CAPPER: Okay.

[242] BY MR. CAPPER:

Q Doctor, are you familiar with the national vaccine program and the fact that Congress, through the Secretary, has established this program among other things to achieve optimal prevention against adverse reaction to vaccines? Are you familiar with that?

A I am not familiar with the details of legislation.

Q At 42 USC 300A-1?

A I am sorry. I am just not familiar with—I have not read the actual legislation. I think I have read the guidelines that come along with this, but I have not read the entire Act.

Q The reason I ask that, doctor, is because a lot of your testimony deals with this microcephaly question and the fact that it is your belief that microcephaly existed from the time of birth, correct?

A That's correct.

Q Having this predisposition as you review the record and as you review the plotting on the growth charts, is it not a fact that the plotting on the growth chart is very, very close and very, very minute as you do that plotting when you look at the head charts in the record at age seven?

A Yes, it is close.

* * * *

[247] Q Looking at H-7, the fourth page, do you have that in front of you?

A H-7? Would you describe what that one is?

Q That is a head growth chart, the big one.

A The big one that says Head Circumference—Girls at the top?

Q Yes.
A Yes.
Q Shortly after birth the child is still on the chart, correct?
A According to this two standard deviations.
Q It is not greater than, though, is it?
A What?
Q It is not greater than two standard deviations, is it?
A No, it is on the second percentile.
Q So according to Menke's definition of microcephaly then that would not be a microcephalic reading, would it?
A Well, according to his definition of being greater than, no, it would not.
[248] Q And according to Nelson it would be either since his definition would be three standard deviations, correct?
A By that definition, no, it would not.
Q Looking at two months of age, under Nelson and Menke we would still be in a situation where under their definition it would not be microcephalic child. Is that correct?
A By those two definitions that is true.
Q At three months, looking at the chart, under Nelson and Menke we would not be under the definition of microcephalic, would we?
A On my graph she would be.
Q No, I am not talking about your graph. I am talking about—
A I am talking about your definition. On this graph she would be.
Q I am looking at it, sir, and that is a dot right on it.
A Which month are you talking about?
Q At three months of age.
A This one does not have a dot at three months.

* * * *

[254] Q Is it my understanding that the record shows that from birth through the first four months if we exclude the fact of microcephalic for a minute that the child had normal growth and normal development?
A Well, there is that reference I alluded to earlier about having feeding difficulties from birth, and then there was another reference from—
Q Let's talk about the feeding difficulties real quickly. That is Dr. Hwang, who saw the child in 1984, is it not?
A That's correct.
Q Other than that doctor, of the doctors that saw this child directly immediately after birth and through the first year of life, did any of those doctors indicate she had feeding difficulties?
A I think there was an implication on that during that one at a later time when she was—
Q My question, doctor, is did you find that the record showed that in fact she had that by her treating physician or any other—
A No. That is the one that I recall.

* * * *

[262] Q And now you are going to say again it is your testimony and opinion that it is purely coincidental that this child had seizures—three or four the night before, one witnessed by a doctor the next day—and a temperature less than 102 degrees and that that is all purely coincidental, sir?
A Absolutely. If I might add—
Q Well, there is no question before you, sir.
THE COURT: If you want to expand on your answer you may do so, doctor.
THE WITNESS: The reason I am stating that is that we see many other children with microcephaly, cerebral palsy, seizures, mental retardation, who start having seizures that are unrelated to anything else that one can make a causal association with—the fullness of the moon or anything. I mean, children with this condition start seizuring at some point.

In early childhood when you are given an immunization every month for three months there is a high likelihood just statistically you are going to hit upon within two or three days or a week of a previous immunization.

* * * *

[279] THE COURT: Where did you come up with it?

THE WITNESS: I have always used it. I guess I learned it where I trained.

THE COURT: Is it a defined medical condition?

THE WITNESS: In the sense of legal? I think any child neurologist would know what one was talking about.

MR. CAPPER: I am going to object to the answer as being non-responsive to the question.

THE COURT: Well, do not waste time objecting. The answer is going to stand. I thought it was responsive.

Were there any signs prior to August 18, 1975, that such a condition existed in Maggie Whitecotton?

THE WITNESS: Other than the things I alluded to earlier—the microcephaly, which I think she had, and the statement that she had chronic feeding problems.

THE COURT: Did you say that the likelihood of a person developing seizures who has microcephaly is 33 percent?

THE WITNESS: Yes, sir, I believe that is the figure that is sometimes used.

* * * *

[282] THE COURT: And what is the evidence of brain undergrowth here, if there is any.

THE WITNESS: The small head. The head size reflects the brain size.

THE COURT: Would an EEG show brain undergrowth?

THE WITNESS: No, sir.

THE COURT: Would a CT scan?

THE WITNESS: The CT scan could show a small brain. That would really not add anything than your small head.

THE COURT: The same thing for an MRI?

THE WITNESS: Yes, sir. It may show more. It may show heterotopias—that is, islands of cerebral gray matter that did not migrate to the cerebral cortex. It may show malformations of the corpus callosum or other things that are commonly associated with a chronic organic brain syndrome.

THE COURT: You have talked about this to some extent. What is the etiology of primary microcephaly?

THE WITNESS: There are several charts and tables which outline a variety of things. Perhaps the most common we see is idiopathic. That is, the child is just born with a small head. We don't know why.

* * * *

[286] THE COURT: But you do not think that as a stressor on the body with a fever it would cause seizure?

THE WITNESS: No.

THE COURT: So do you think looking retrospectively at this case that that is an incorrect diagnosis?

THE WITNESS: Yes.

THE COURT: Was it an improper diagnosis to consider at the time?

THE WITNESS: I am not sure if it was improper because I think at the time there were a lot of opinions circulating that DPT was commonly associated with seizures. That was about the period of time that the first British survey came out. Certainly there was a long anecdotal history leading up to that point.

I think a lot of people, perhaps including myself, at that time assumed there was a causal relationship.

THE COURT: When you came into this case did you at that point have an opinion as to whether or not the DPT vaccine causes permanent neurological disorders?

THE WITNESS: I think if I remember correctly it [287] was my opinion at the time that it did not.

THE COURT: So your opinion has not changed during the last year or so?

THE WITNESS: No, I don't think it has changed, but in all honesty, I do try to keep an open mind when reading literature.

THE COURT: Does the fact that you have that opinion affect the opinion you reached in this case as to whether or not Maggie was microcephalic at any time during her life?

THE WITNESS: That has no bearing on that whatsoever.

THE COURT: Does it affect your opinion as to whether or not at encephalopathy occurred within three days following the vaccination on August 18, 1975?

THE WITNESS: No. There is no fact of that. I can't remember the case, but there was another pertussis case. It was not related to this. It is my opinion that I would allow a pertussis immunization if there was a sign of brain injury at the time; that is, altered consciousness and things of that nature. I would be open enough to say that that is a possibility.

* * * *

HOOSIER NEUROLOGY, P.C.

[Addresses Omitted in Printing]

September 11, 1991

John Capper
Attorney at Law
108 North Green Street
Crawfordsville, Indiana 47933

RE: MARGARET A. WHITECOTTON
DOB: 04/22/75

Dear Sir:

I am writing to you in regards to Margaret Ann Whitecotton and to her medical condition in 1975, when she suffered an adverse reaction to DPT immunization. The patient's adverse reaction to the DPT immunization is described in her hospital records when she was hospitalized at Riley Children's Hospital in August, 1975 under the care of Drs. Drew and Wissman on the neurology service.

Her hospital records include some laboratory studies that confirm the presence of demyelinating central nervous system disturbance which is characteristic of the problems associated with adverse reactions to immunization. The CSF studies performed at the time of her initial insult, August 22, 1975, show changes that are characteristic of a CNS demyelinating disease as expected from the adverse reaction to the DPT immunization.

The patient's seizure, encephalopathy, and associated neurological problems were caused by the pertussis immunization, in the opinion of Drs. Drew and Wissman.

The patient was seen later at Riley Hospital at age ten months and at that time had follow-up CSF studies on March 3, 1976. These CSF studies do demonstrate some

nonspecific chronic inflammatory changes, but the previously noted demyelinating changes seen in the CSF studies of August 22, 1975, had resolved. The presence of the acute demyelinating changes at the time of the insult and later resolution of these changes is consistent with an acute and transient demyelinating central nervous system disturbance.

At the time the patient was initially hospitalized at Riley Children's Hospital in August, 1975, Dr. Drew made some comments regarding the use of immunizations in children especially children who might have some central nervous system disturbance. These comments which were mentioned in the discharge summary by Dr. Wissman should be considered generic comments regarding the problem of immunizing children with central nervous system isults and do not appear to directly reflect his management of Margaret Ann Whitecotton.

Should you have further questions regarding Ms. Whitecotton's clinical course or her laboratory studies, please feel free to contact me.

Sincerely yours,

/s/ Paul F. Bustion M.D.
PAUL F. BUSTION, M.D.
PFB/dge

CC: M.G. Whitecotton

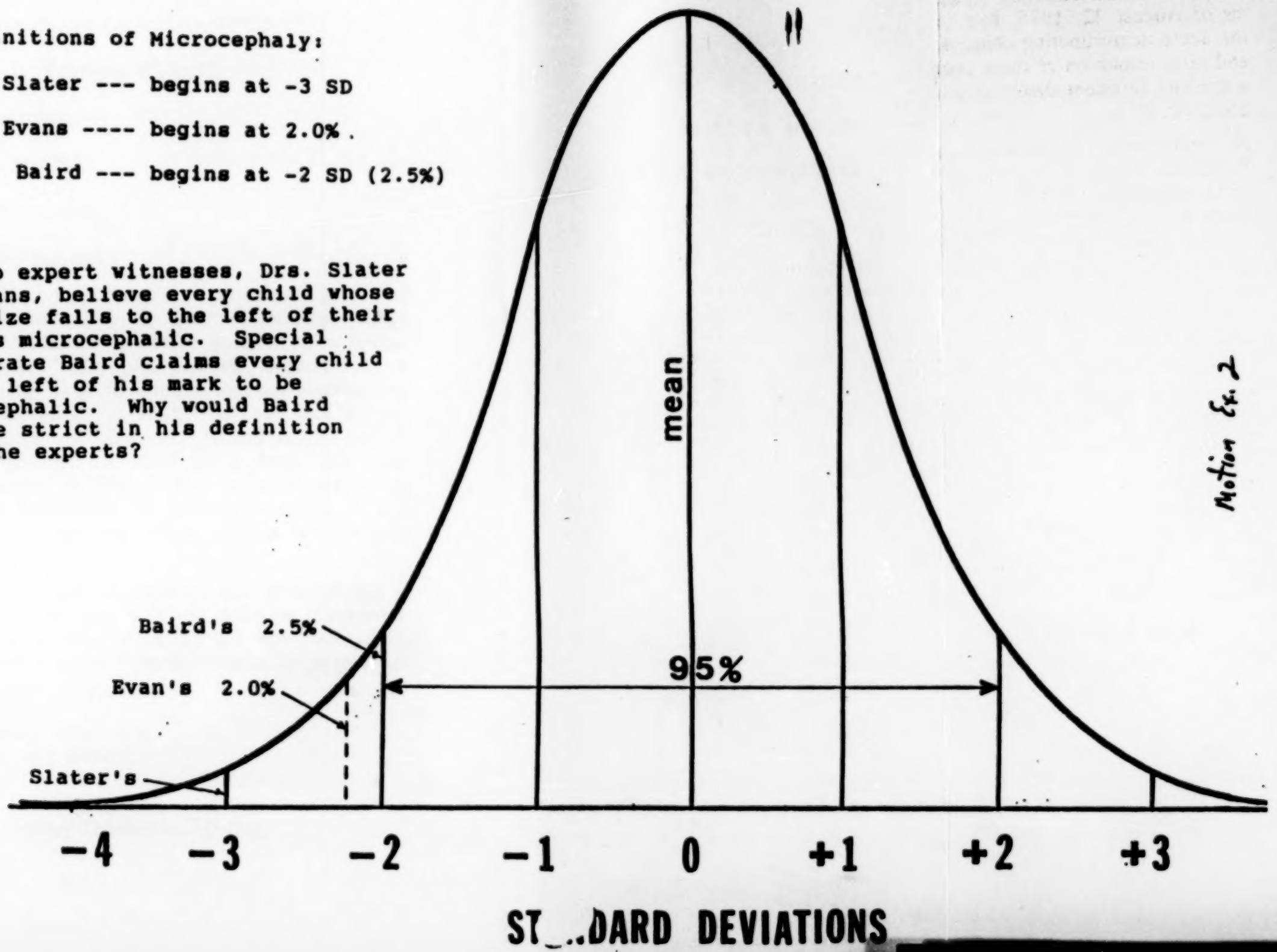
Definitions of Microcephaly:

Dr. Slater --- begins at -3 SD

Dr. Evans ---- begins at 2.0%.

S.M. Baird --- begins at -2 SD (2.5%)

The two expert witnesses, Drs. Slater and Evans, believe every child whose head size falls to the left of their mark is microcephalic. Special Magistrate Baird claims every child to the left of his mark to be microcephalic. Why would Baird be more strict in his definition than the experts?



Motion Ex. 2

M. KEITH BAIRD, M.D.
215 Ward Avenue
Crawfordsville, Indiana 47933

February 13, 1992

Mrs. Kay Whitecotton
13 Twin Oaks
Crawfordsville, IN 47933

Re: Maggie Whitecotton

To Whom It May Concern:

I have been asked to comment on the meaning of the statement "ENT-Normal" in my letter to Dr. Drew dated August 19, 1975. There was some question by a lawyer that "ENT-Normal" did not include observation of normal swallowing. It is my opinion that my observations did include observations of swallowing and that no abnormal swallowing was observed. Indeed in the second paragraph I "watched the child for a long time" and specifically observed sucking (which includes swallowing motion). Then I observed the sucking stopping. I specifically noted the gag reflex which involves the swallowing mechanisms.

The legal system tends to conclude that if something is not specifically stated that it wasn't done or observed—this is an erroneous view. After all if I wrote everything normal I observe I would have to write a 20 page chapter of an ENT book on each patient.

/s/ M. Keith Baird, M.D.
M. KEITH BAIRD, M.D.
MKB/dab
cc:file

[Notary Omitted in Printing]

AFFIDAVIT

I, Kay Whitecotton, being first duly sworn upon my oath, say that I am the mother of Margaret Whitecotton. At the time of the hearing before Special Master Baird that those statements were untrue and that she did not have and had not had swallowing problems since birth. That Special Master Baird made a finding that he considered the statement of Dr. D.S. Hwang, M.D. that she had had a swallowing problem since birth was credible. That in preparing for the appeal on this case, the undersigned became concerned about the statement made by Special Master Baird in his decision and on or about the latter part of February, 1992, I contacted Dr. Hwang about the statement he had made on August 28, 1979 that "she has had a swallowing problem since birth".

When I talked with Dr. Hwang the latter part of February, 1992, he advised that before he could answer any questions, he would have to review records. He reviewed all the records and advised me that she categorically had no swallowing problems since birth, as evidenced by his February 24, 1992 letter. That at the time of the hearing before the Special Master, I was not specifically aware of Dr. Hwang's statement in the multitude of medical records, but when questioned, I did rebut Dr. Hwang's statement. I did testify to this but Special Master Baird did not find my evidence credible as opposed to that of the Dr. Hwang. Specifically now, the letter of Dr. Hwang clearly indicates to the contrary making the conclusion drawn by Special Master Baird incorrect. I did not know that this specific evidence would come into play with regard to the Court's decision until the Court, in its decision, refused to believe my statement as the mother of Margaret Whitecotton. Therefore, I decided to contact Dr. Hwang and obtain this information on February 24, 1992. See attached letter from Dr. Hwang.

At the same time, I contacted M. Keith Baird, M.D. who was the treating physician who observed Maggie

having an adverse reaction to the DPT shot on August 19, 1975. I contacted him because there was a question or doubt by Special Master Baird and/or the government about Maggie having swallowing problems. Dr. Baird concluded that she had no abnormal swallowing problems. See his letter of February 13, 1992. This information was not available at the last hearing because I did not know that Special Master Baird or the government would try to re-interpret Dr. Baird's letter or mis-state his conclusions.

Further, that after the decision by the Special Master, I decided to gather additional information for my attorney in preparation of any appeal brief and asked my neighbor, Dr. Timothy Tanselle, to schedule an appointment for me with a neurologist in Indianapolis. He did schedule an appointment for me with Dr. Bustion of Hoosier Neurology. My husband and I went over to see him which resulted in a letter which was included in a motion for hearing before the Court dated September 11, 1991. At the time of that meeting, Dr. Bustion did not mention anything about being present when Maggie was diagnosed at Riley Hospital.

That on February 18, 1992, when I again met with Dr. Bustion and John S. Capper, IV, who desired to obtain information that might be helpful in the appeals case, he indicated for the first time that he was present when Dr. Drew made his diagnosis of Maggie, stating that she had suffered from post-immunization encephalopathy, or an adverse reaction to the DPT shot. This was quite shocking to me that someone else was present at the time Dr. Drew made his diagnosis and who is also in the field of neurology. That this person would be an excellent witness to further inform the Court as to Maggie's condition and her adverse reaction. That this person was not available and only through pure coincidence did I come to know about Dr. Bustion.

That after the Court's decision, I became so upset with the Court's interpretation that my daughter was micro-

cephalic since birth that even though the obstetrician's records who delivered her were in the record, I contacted him on March 12, 1992 and advised him that Special Master Baird and other medical experts were saying that my daughter was microcephalic since birth. Pursuant to the medical records already in the case and a most recent letter from him, Maggie has not been microcephalic since birth. See attached letter from Jack Foltz, M.D.

And further Affiant saith not.

/s/ Kay Whitecotton
KAY WHITECOTTON

[Notary Omitted in Printing]

HOOSIER NEUROLOGY, P.C.

[Adresses Omitted in Printing]

March 23, 1992

Mr. and Mrs. Michael Whitecotton
#13 Twin Oaks
Crawfordsville, Indiana 47933

Dear Mr. and Mrs. Whitecotton:

I am writing to you in regards to Margaret Ann Whitecotton, your daughter, and acknowledging that I met with Kay Whitecotton, her mother, and John S. Capper, IV, your attorney, on February 18, 1992 in my office. While reviewing Maggie's case and having reviewed the discharge summary from Riley Hospital of Indiana University Hospitals, dated August 20, 1975, I realized that that this case was familiar, and that I was present at Riley Hospital August 19, 1975 when Margaret Ann Whitecotton was a patient of Dr. Les Drew, her attending physician, at which time he made his diagnosis.

Although I had written a letter to John S. Capper, IV, your attorney, in September of 1991 regarding Margaret Whitecotton, I did not recall until my meeting of February 18, 1992, when reviewing medical information in detail that I had been present when Dr. Drew made his diagnosis of post immunization encephalopathy.

I now affirm, under oath, by way of this letter that Dr. Drew diagnosed Maggie Whitecotton as having an adverse reaction to a DPT shot, particularly, post immunization encephalopathy, with associated seizures. I specifically recall Dr. Drew explaining to us the encephalopathy, seizure disorder, and other neurological problems, as a consequence of the Pertusis immunization, in the opinion of Dr. Drew. Dr. Drew at the time was the head of the Pediatric Neurology Department at Riley Hospital. Dr.

Drew did not state nor did he consider her condition to be the result of microencephaly.

I acknowledge that I wrote a letter on September 11, 1991 to John S. Capper, IV, your attorney, discussing Maggie's condition, however, at the time, I did not realized that she was a patient that I had attended with Dr. Drew when she was diagnosed by Dr. Drew in 1975 with post immunization encephalopathy.

At the time of my conversation with Mrs. Whitecotton, and Mr. Capper I reviewed with them also the electroencephalography report of August 25, 1975, showing an EEG poorly organized and slightly slow for her age. I also reviewed an electroencephalogram dated September 29, 1975 that indicated the EEG was within normal limits. It is my medical opinion, based upon a reasonable degree of medical certainty and pursuant to the National Childhood Vaccine Injury Act, that the patient's condition was one of encephalopathy as defined in the National Childhood Vaccine Injury Act. The electroencephalogram reports collaborates this finding.

Sincerely yours,

/s/ Paul F. Bustion, M.D.
PAUL F. BUSTION, M.D.
PFB/dge

Paul F. Bustion, M.D.
1801 North Senate Boulevard, Suite 510
Indianapolis, Indiana 46202
Phone: (317) 929-5910

CURRICULUM VITAE

Date of Birth:	**September 1, 1949**
Social Security #:	**314-48-7962**
Birthplace:	**Victoria, Texas**
Marital Status:	**Married—Barbara K. Bustion (1975)**
Dependents:	**Two children**
Home Address:	**837 Forest Drive Anderson, Indiana 46016**
High School:	**William Henry Harrison Evansville, Indiana 1963-1967 Graduation—June 1967**
Pre-Med:	**St. John's College Santa Fe, New Mexico 1967-1971 Graduation—June 1971 B.A. Degree**
Medical School:	**Indiana University School of Medicine 1971-1976 M.D.—June 1976**
Internship:	**Indiana University Hospitals 1976-1978 Pediatrics**
Residency:	**Indiana University Hospitals 1977-1978 Pediatrics**
Residency:	**Indiana University Hospitals 1978-1981 Neurology**

Medical License:	1976—325578
Military Service:	None
Teaching Appointments:	Indiana University Department of Neurology Clinical Professor of Neurology 1981-Present
Medical Societies:	American Academy of Neurology 1980-Present Associate Member
	Indiana Neurological Society 1978-Present
	AMA, ISMA, Madison County Medical Society 1981-Present
	American Institute of Ultrasound in Medicine 1982-Present
CME:	Attached
References:	To be provided
Hospitals:	St. John's Hospital Medical Center Anderson, Indiana
	Community Hospital of Anderson Anderson, Indiana
	Methodist Hospital of Indiana Indianapolis, Indiana
	Winona Memorial Hospital Indianapolis, Indiana
	Johnson County Memorial Hospital Franklin, Indiana
Malpractice:	Physician's Insurance Company of Indiana

JACK L. FOLTZ, M.D.
Obstetrics & Gynecology
297 West Franciscan—Suite 201
Crown Point, Indiana 46307
(219) 862-1320

March 12, 1992

TO WHOM IT MAY CONCERN:

I was Kay Whitecotton's obstetrician for her delivery with Maggie. There was no problem with her pregnancy or delivery. Maggie was small but completely normal and not microcephalic.

Maggie had no problems until her episode following a DPT Vaccination. I feel that her neurological condition now is due to this unfortunate reaction and was not present before the Vaccination.

Sincerely,

/s/ Jack L. Foltz, M.D.
JACK L. FOLTZ, M.D.

[Notary Omitted in Printing]

[LOGO]

INDIANA UNIVERSITY
SCHOOL OF MEDICINE

Department of Orthopaedic Surgery
Section of Pediatric Orthopaedics
James Whitcomb Riley Hospital for Children 1101
702 Barnhill Drive
Indiana University Medical Center
Indianapolis, Indiana 46202-5215
(317) 274-5650

March 6, 1992

Re: Margaret Whitecotton

TO WHOM IT MAY CONCERN:

Maggie Whitecotton has been under my care for her orthopaedic problems since 1979. Maggie had dislocation of the hip secondary to muscle imbalance due to her cerebral palsy. She did not have a congenital dislocation of the hip.

If there are any further questions, feel free to contact my office directly.

Yours sincerely,

/s/ G. Paul DeRosa, M.D.
G. PAUL DEROSA, M.D.
Professor and Chairman
Department of Orthopaedic Surgery

GPD/smb

[Notary Omitted in Printing]

DO S. HWANG, M.D., F.A.A.P.
1704 North Lafayette Road
Crawfordsville, Indiana 47933

Telephone 362-5100

March 12, 1992

Patient: Margaret Ann Whitecotton

To Whom It May Concern:

Maggie's parents have asked me to review the accuracy of the statement "she has had a swallowing problem since birth" which appeared on a Culver Hospital record dated 8-28-79. I have researched my files and other physicians' files. Based upon my personal knowledge, Maggie had no swallowing problem at birth or at an early age.

The following things verify or support this statement:

1. I saw Maggie in my office four times prior to the hospital stay in question. The visits were from 7/19/77 thru 6/3/79. On Maggie's first visit, I noted her mother stated she was eating well. On the three following visits nothing was ever mentioned or observed during the examinations of a swallowing problem. If it had been mentioned or detected, I would have definitely noted it on her file.
2. Maggie had other doctors before 8-28-79 and my personal review of their notes show no swallowing problems.

a. 4-22-75 Admitting physician, J.M. Foltz M.D., stated no abnormalities, and the sucking and swallowing reflexes were normal.

b. 4-25-75 Discharging physician, W.E. Shannon M.D., stated no abnormalities, and the sucking and swallowing reflexes were normal.

c. 8-19-75 Associate family physician, M.K. Baird M.D., stated prior examinations had been normal. Ear, nose, and throat and the gag reflex exam was normal. I note the letter from Dr. Baird (2-13-92) clarifies his observation.

d. 8-20-75 Indiana University (Riley Hospital for Children) physician, S. Wissman M.D., stated in discharge summary that Maggie was sucking on pacifier and the ENT was normal. (Nurse noted that Maggie was eating solids well).

e. 2-24-76 Indiana University (Riley Hospital for Children) nurse's notes, stated mother fed the child solid foods. (There was no mention of swallowing problems throughout the report).

f. 1-16-77 Family physician, J.C. Shank M.D., lists her feeding as normal table food. (There is also no mention of a swallowing problem).

On 8-28-79 Maggie was brought to the emergency room with her mother in panic. Maggie was pale and limp. She had just experienced rolling eyes and loss of color. She had become still and didn't respond to her mother's stimulation. These are typical characteristics of a seizure (a seizure was recorded on the hospital record). Abnormal swallowing accompanies a seizure. Her records show that her first seizures and a dinosis of post-immunization encephalopathy occurred following her third DPT shot at the age of four months.

While conversing with a parent or a close friend, I must have noted something about the swallowing that commonly accompanies a seizure. It is also possible an error in the transcription may have occurred.

I can categorically state that, other than the 8-28-79 entry, there is not substantive backing in the records or reports of the previously listed doctors, that would indicate that Maggie had a swallowing problem at birth or an early age.

Sincerely,

/s/ D.S. Hwang, M.D.
D.S. Hwang, M.D. F.A.A.P.

[Notary Omitted in Printing]

IN THE UNITED STATES CLAIMS COURT
OFFICE OF THE SPECIAL MASTERS

(Filed: September 15, 1992)

No. 90-692V

PUBLISH

MARGARET WHITECOTTON, by her next friends,
KAY WHITECOTTON AND MICHAEL WHITECOTTON,
PETITIONERS

v.

SECRETARY OF THE DEPT. OF
HEALTH AND HUMAN SERVICES, RESPONDENT

ORDER[1]

BAIRD, Special Master

Procedural Background

On January 29, 1992, judgment was entered in the above-entitled matter denying the petitioners' claim for compensation under the National Vaccine Injury Compensation Program. On March 27, 1992, the petitioners filed a petition for review of the decision of the Claims Court in the United States Court of Appeals for the Federal Circuit. Three days after filing the appeal, the petitioners filed a motion in this court to set aside the

[1] Although the Order of Remand filed July 1, 1992 indicated that the undersigned should "submit a report . . . with . . . recommendation for disposition" of the motion, it also provided that the undersigned's "ruling on the motion" should be handled in all respects as a final decision. It is for that reason that the report is being issued in the form of an order. Review of this order may be obtained by filing a motion for review pursuant to 42 U.S.C.A. § 300aa-12(e) (West 1991) within 30 days.

judgment and for rehearing on their petition, pursuant to RUSCC 60(b), based on newly discovered evidence. A brief in response to the motion—urging that it be summarily rejected—was filed by the respondent on April 13, 1992. The motion was remanded by the court to the undersigned on July 1, 1992 for appropriate action. At a status conference held by the undersigned on July 23, 1992, petitioners requested and were granted leave to file an amended motion. The amended motion, with additional exhibits, was filed on August 25, 1992.[2] After reviewing the written filings, argument was deemed unnecessary.

This Court Has Authority To Deny The Motion
Without Seeking Remand

RUSCC 60(b) provides that "[o]n motion and upon such terms as are just, the court may relieve a party or the party's legal representative from a final judgment, order, or proceeding for the following reasons: . . . (2) newly discovered evidence which by due diligence could not have been discovered in time to move for a new trial under Rule 59(b); . . . ."[3]

The respondent opposed the motion on two grounds: (1) that the filing of the appeal divested this court of jurisdiction to grant the motion; and (2) that the motion is without merit under Rule 60(b).

The court agrees with the respondent on both points. Under the holdings in *Placeway Construction Corp. v.* U.S., 19 Cl. Ct. 484 (1990), and *Yachts America, Inc.*

[2] The amended motion seeks to invoke RUSCC 59 as well as RUSCC 60(b), even though the original motion acknowledged that a motion under Rule 59 would be untimely. Because the petitioners failed to comply with the time requirements of RUSCC 59, the special master has applied the standard set out in RUSCC 60(b) in assessing the merits of the motion, as amended.

[3] A motion for a new trial under RUSCC 59(b) must be filed within ten days after the entry of judgment.

v. U.S., 8 Cl. Ct. 278 (1985), *aff'd*, 779 F.2d 656 (Fed. Cir. 1985), *cert. denied*, 479 U.S. 832 (1986), which this court chooses to follow, once the appeal was filed, the Claims Court lost jurisdiction over the case except to act in aid of the appeal or to correct clerical errors. Under its authority to act in aid of the appeal, this court may deny a Rule 60(b) motion, but it does not have jurisdiction to grant such a motion. If it is inclined to grant the motion, it may inform the appellate court of its inclination and request remand, but it may not grant the motion unless the case is remanded by the appellate court.[4]

Relief Is Not Warranted Under RUSCC 60(b)

Yachts America provides the following guidance in determining whether to grant a Rule 60(b) motion:

> When seeking relief because of "newly discovered evidence," the party must show "(1) that the evidence was actually 'newly discovered'; that is, it must have been discovered subsequent to the trial; (2) that the movant exercised due diligence; and (3) that the evidence is material, not merely impeaching or cumulative, and that a new trial would probably produce a different result." (quoting *Warner v. Transamerica Insurance Co.*, 739 F.2d 1347, 1353 (8th Cir. 1984). . . .
>
> Newly discovered evidence is evidence of facts which existed at the time of decision and of which the aggrieved party was excusably ignorant. (citation omitted) To be excusably ignorant, of course, the party must have exercised due diligence in locating the evidence. And the evidence may not be merely cumulative; it must be such as would alter the outcome of the case. (citations omitted)

8 Cl. Ct. at 281.

[4] The wording of the stay order of the Federal Appeals for the Federal Circuit filed June 26, 1992, which provided that a motion for remand should be filed if this court indicated an inclination to grant the motion, is consistent with this analysis.

The court in *Placeway Construction Corp.* noted, further, that "a Rule 60(b) 'motion for relief from judgment is one for extraordinary relief entrusted to the discretion of the Court . . . which may be granted only in exceptional circumstances.'" 19 Cl. Ct. at 489 (quoting from *Sioux Tribe of Indians v. United States*, 14 Cl. Ct. 94, 101 (1987), *aff'd*, 862 F.2d 275 (Fed. Cir. 1988), *cert. denied*, 490 U.S. 1075 (1989)).

The respondent argues that the "newly discovered evidence" offered by the petitioners fails two of the three requirements set out in *Yachts America*: it could have been discovered by due diligence before the hearing, so petitioners were not excusably ignorant of it; and it would not be likely to produce a different result if it were part of the record. Although they do not apply equally to all of the proffered evidence, these arguments are well taken.

The first two items of evidence proffered deal with the issue of whether Maggie Whitecotton had a swallowing problem prior to receiving the DPT vaccine. The first, exhibit (hereinafter Ex.) AA [5], is a statement from a treating doctor, Do S. Hwang, M.D., indicating that he has reviewed Maggie's records and finds no support for an entry which appeared in his records to the effect that Maggie had had swallowing problems since birth. The petitioners were aware of that entry prior to the hearing—it appeared in documents filed by them—and they could have contacted Dr. Hwang concerning it be-

[5] The memorandum in support of the motion to set aside the judgment filed March 30, 1992 mistakenly refers to the exhibit as "CC." Such erroneous referencing appears consistently throughout the memorandum.

fore the hearing. This, then, does not qualify as newly discovered evidence. It is merely an effort to raise doubts about (*i.e.*, impeach) the validity of record evidence. The second, Ex. BB, is a letter from another treating physician, M. Keith Baird, M.D., indicating that when he included the observation "ENT-Normal" in a letter dated August 19, 1975, the observation included observations of swallowing. This, too, is merely a clarification of a record which could easily have been obtained prior to the hearing. More telling, though, for both of these items, is their insignificance. Counsel for petitioners should recognize that the decision of the special master did not turn on whether Maggie had swallowing problems from birth. The decision referred to the swallowing issue as only a "hint" that Maggie might have had preexisting neurologic complications, and went on to state that "there was little evidence of complications of microcephaly prior to August 18, 1975." Slip op. at 9, 10 (Cl. Ct. Spec. Mstr. Aug. 16, 1991). The proffered evidence on swallowing problems would not produce a different result.

The third proffered item of evidence, Ex. CC, is a letter from Paul F. Bustion, M.D., recalling what he was told by Dr. Les Drew concerning the cause of Maggie's encephalopathy, seizure disorder, and other neurological problems. While the evidence in this letter could probably not have been discovered by due diligence prior to the hearing, it is considered to be a less reliable indicator of what Dr. Drew's opinion was than the entries made in 1975 in Maggie's medical records. It is clear from those entries that Dr. Drew was of the opinion that Maggie was microcephalic and had preexisting brain damage and that he was concerned about further indications of "CNS dysfunction associated with microcephaly." Ex. F to petition at 1-2. The decision filed August 16, 1991 recognized that the treating physicians considered Maggie to have suffered an acute "postimmunization encephalopathy

with seizures." However, according to the records, Dr. Drew attributed her root problem to preexisting brain damage and microcephaly. Dr. Bustion's letter would not produce a different result.

The fourth proffered item, Ex. DD, is a statement from the doctor who delivered Maggie stating that she was not microcephalic at birth and opining that her present condition is due to an unfortunate reaction to the DPT vaccine. The opinion testimony clearly falls outside the realm of newly discovered evidence. The statement as to whether Maggie was microcephalic at birth does not change anything. The special master's decision found "that Maggie was at least borderline microcephalic at birth and that she was clearly microcephalic by the time she received her third DPT shot." Slip op. at 7. That finding is accurate based on medical standards for determining microcephaly, and nothing Dr. Foltz has said changes that. His statement would not produce a different result.

The final item filed with the original motion, Ex. EE, is a letter from G. Paul DeRosa, M.D., an orthopedic surgeon who has treated Maggie since 1979. Dr. DeRosa states that Maggie's hip dislocation was not congenital, but secondary to muscle imbalance due to her cerebral palsy. The decision noted that Maggie's medical records consistently refer to her hip dislocation as being congenital. The testimony of Dr. DeRosa, which is impeaching in character, is also evidence which could have been obtained prior to the hearing; but it doesn't matter in the context of this case whether Maggie's hip dislocation was congenital or secondary to her cerebral palsy because the court has found that her cerebral palsy is not vaccine-related.[6] Dr. DeRosa's letter does not speak to that issue and would not produce a different result.

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[6] This same point was made by Judge Turner in his Opinion and Order filed January 14, 1992, at n.6.

In the amended motion, the petitioners argue that there is newly discovered evidence which was not available and could not have been discovered prior to trial with due diligence which is likely to lead to a change in the original result. As evidence they offer excerpts from two medical treatises, Exs. HH and II, which, they assert, show that demyelination occurs in encephalopathies following DPT immunization.[7] No assertion is made that these sources were not available prior to the hearing. Rather, petitioners argue that their counsel was misled by the special master prior to the hearing into believing that they had established a Table case, so that he did not prepare the case as he would have had he thought he was going to have to prove that a Table injury occurred.

The petition alleged that an encephalopathy had occurred following the DPT vaccination, but made no allegation concerning a residual seizure order. At the initial status conference, the special master, pursuant to Vaccine Rule 5, provided the parties with his initial assessment of the case. That conference was off the record. The recollection of the special master is that he advised the parties that there was no clear evidence in the record of an encephalopathy following the vaccination and that there was some indication of a preexisting brain anomaly. He noted that Maggie had suffered multiple afebrile seizures on the day following the vaccination and that, if those were her first seizures, she would meet the threshold requirement for establishing a residual seizure disorder. He also noted that there was an indication in the record that she may have had earlier seizures and that that needed to be explored. The special master did not rule at that conference that the petitioners were entitled to an award based on a residual seizure disorder. Any such ruling would have been put in writing.

[7] Exhibit II does not even mention DPT vaccine.

The order issued following the initial status conference indicated that a hearing limited to the issue of entitlement would be held at a time yet to be determined. When such an order is issued, it indicates that no decision concerning entitlement has been made and that the special master has enough reservations about entitlement to bifurcate the entitlement and compensation portions of the case.

When the petitioners moved for summary judgment on the residual seizure disorder during their opening statement at the hearing, the motion was denied. The petitioners did not move for a continuance or make any claim that they had detrimentally relied on representations made by the special master in preparing their case for hearing. If they believed they had cause to complain, they should have done so then, not after judgment.

The raising of the question of demyelination in the amended motion is nothing more than an improper attempt to retry the issue of whether an encephalopathy occurred following the vaccination. There is no basis for concluding that there is *any* newly discovered evidence, let alone that it is evidence which could not have been discovered by due diligence prior to the hearing.

The petitioners have proffered nothing—whether considered individually or collectively—which would come close to producing a different result if it had been made part of the record at the hearing. Their motion is without merit under Rule 60(b) and is, therefore, DENIED.

/s/ Paul T. Baird
PAUL T. BAIRD
Special Master

IN THE UNITED STATES COURT
OF FEDERAL CLAIMS
January 7, 1993

No. 90-692V

MARGARET WHITECOTTON, by her next friends,
Kay Whitecotton and Michael Whitecotton, PETITIONER,

versus

SECRETARY OF THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES, RESPONDENT.

[Filed Jan. 7, 1993]

John S. Capper, IV, Crawfordsville, Indiana, for petitioner.

Karen P. Hewitt, with whom were Assistant Attorney General Stuart M. Gerson, Helene M. Goldberg, John Lodge Euler and Charles R. Gross, Washington, D.C., for respondent.

OPINION AND ORDER

TURNER, Judge.

This action stands on petitioner's motion under RCFC 60(b) for relief from judgment based on newly discovered evidence. We conclude, based on the recommendation of the special master, that petitioner's motion should be denied.

I

In August 1990, Maggie Whitecotton filed a petition seeking compensation under the National Childhood Vaccine Injury Act of 1986, 42 U.S.C. §§ 300aa-10-300aa-34 (1988), *as amended* by several public laws codified in 42 U.S.C.A. §§ 300aa-10—300aa-34 (West Supp. 1991) (Vaccine Act), for injuries allegedly suffered as a result

of a diphtheria-pertussis-tetanus (DPT) vaccination. After conducting an evidentiary hearing, the special master issued a decision denying compensation. We sustained the special master's decision in an opinion dated January 14, 1992, and judgment for the respondent was entered on January 29, 1992.

On March 27, 1992, petitioner appealed the decision to the United States Court of Appeals for the Federal Circuit, and three days later, on March 30, 1992, petitioner filed a motion under RCFC 60(b) for relief from judgment based on newly discovered evidence. The Federal Circuit stayed the proceedings pending resolution of the Rule 60(b) motion by the Court of Federal Claims.[1] On July 1, 1992, we referred the case to the special master for proceedings to assist in the resolution of the Rule 60(b) motion. In a September 15, 1992 report, the special master recommended that the motion for relief from judgment be denied.[2] Petitioner responded by filing

[1] In granting petitioner's motion to stay the proceedings, Judge Rader stated:

> It is the usual practice of this court to stay proceedings pending a trial court's ruling on a 60(b) motion. If the motion is denied, any appeal should be promptly filed and consolidated with the underlying appeal. If the trial court indicates that it is inclined to grant such a motion, then a motion to remand should be promptly filed.

Order of the Court of Appeals, Rader, Circuit Judge (June 25, 1992).

[2] The special master, who issued his recommendation in the form of an order, noted his confusion with the Order of Remand as follows:

> Although the Order of Remand filed July 1, 1992 indicated that the undersigned should "submi[t] a report . . . with . . . recommendation for disposition" of the motion, it also provided that the undersigned's "ruling on the motion" should be handled in all respects as a final decision. It is for that reason that the report is being issued in the form of an order. Review of this order may be obtained by filing a motion for re-

a "motion for review" of the special master's report. Familiarity with the orders previously issued in this case is assumed.

II

Petitioner seeks relief from judgment under Rule 60(b) due to newly discovered evidence.[3] Under Rule 60(b)(2), the court may relieve a party from a final judgment if there is "newly discovered evidence which by due diligence could not have been discovered in time to move for a new trial under Rule 59(b)."[4] A motion for relief from judgment under Rule 60(b) may be granted only in exceptional circumstances. *See Washington Medical Center, Inc. v. United States*, 211 Ct. Cl. 379, 379-80 (1977); *Sioux Tribe of Indians v. United States*, 14 Cl. Ct. 94, 101 (1987), *aff'd* 862 F.2d 275 (Fed. Cir. 1988),

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view pursuant to 42 U.S.C.A. § 300aa-12(e) (West 1991) within 30 days.

Order of Special Master, No. 90-692, slip op. at 1 n.1 (September 15, 1992).

Because we did not intend for the special master to issue a "final decision" but instead to make a "recommendation for disposition," we will treat the special master's report as merely a "recommendation." As such, we will not apply the exacting standard of review embodied in 42 U.S.C.A. § 300aa-12(e)(2). Instead, we consider petitioner's motion in the first instance.

[3] A substantial portion of petitioner's motion for review objects to legal rulings in this court's original decision. None of the objections relating to this court's original decision in this case should be revisited under Rule 60(b). That decision is already the subject of an appeal to the Federal Circuit, and each of the alleged errors in this court's original decision may be properly considered by the appellate court. *See Pierce v. UMW*, 770 F.2d 449, 451 (6th Cir. 1985), *cert. denied*, 474 U.S. 1104 (1986) (holding that a claim of legal error is not a basis for relief under Federal Rule of Civil Procedure 60(b)); *Martinez-McBean v. Virgin Islands*, 562 F.2d 908, 911 (3rd Cir. 1977) (same).

[4] A motion under RCFC 59(b) must be filed within ten days after the entry of judgment.

cert. denied, 490 U.S. 1075 (1989). When seeking relief under Rule 60(b), a party must show:

> (1) that the evidence was actually "newly discovered"; that is, it must have been discovered subsequent to the trial; (2) that the movant exercised due diligence; and (3) that the evidence is material, not merely impeaching or cumulative, and that a new trial would probably produce a different result.

Yachts America, Inc. v. United States, 8 Cl. Ct. 278, 281, *aff'd* 779 F.2d 656 (Fed. Cir. 1985), (quoting *Warner v. Transamerica Insurance Co.*, 739 F.2d 1347, 1353 (8th Cir. 1984)).

Petitioner's alleged newly discovered evidence consists of five affidavits from physicians and two excerpts from medical treatises. *See* Petitioner's Exhibits AA-EE, HH & II.[5] We will discuss the substance of these items seriatim and then will address whether any of these items constitute "newly discovered evidence."

A

Two of the affidavits pertain to the issue of whether Maggie had a swallowing problem before she received the vaccine.

Exhibit AA is the affidavit of Dr. Hwang who was Maggie's treating physician at the time of her 1979 hospitalization. In his affidavit, Dr. Hwang asserts that based upon his personal knowledge and his review of other doctors' notes, Maggie did not have a swallowing problem before she received the vaccine. Petitioner submitted this affidavit because an entry appeared in Dr. Hwang's medical records concerning Maggie that said that she "has had difficulty swallowing since birth." Petitioner's Exhibit H-

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[5] Exhibits FF, GG and JJ were also submitted as part of petitioner's motion, but these exhibits constitute affidavits that were submitted to justify the post-judgment discovery of the evidence, not as examples of newly discovered evidence.

12. The special master relied on exhibit H-12 as evidence of a "hint" that Maggie may have had neurological complications before the vaccine was administered. SMD at 9.

Exhibit BB is the affidavit of Dr. Baird, a family physician who performed an ear, nose and throat examination on Maggie in 1975. In an August 19, 1975 letter to another physician, Dr. Baird indicated that Maggie was "ENT-Normal." In his affidavit, Dr. Baird states that his examination of Maggie included an observation of normal swallowing.

Two of the affidavits pertain to the issue of whether Maggie was microcephalic before the vaccine was administered.

Exhibit CC is the affidavit of Dr. Bustion, a consulting physician who was present during Maggie's August 1975 hospitalization. At the conclusion of Maggie's hospitalization, treating physicians prepared a written discharge diagnosis which said, in part:

> Discharge Diagnosis: (1) Microcephaly (2) Postimmunization encephalopathy with seizures.
>
> . . .
>
> DISPOSITION: It was thought that the patient's seizures were most likely secondary to the pertussis vaccine which she had received earlier in the day. It was Dr. Drew's feeling that children with microcephaly and some brain damage were unusually susceptible to this vaccine. It was decided to not start this child on any anticonvulsive medications at this time. The child will be followed by Dr. Drew in his office for any further seizure difficulty or any other evidence of CNS dysfunction associated with the microcephaly.

PX F. In his decision denying compensation, the special master relied on this statement:

> It is reasonable to infer from the discharge diagnosis and this statement that at least some of the treating physicians (1) considered Maggie to be microcephalic; (2) thought that she might have preexisting brain damage; (3) considered her seizures to have been immediately secondary to the DPT vaccine but ultimately evidence of CNS dysfunction associated with microcephaly; (4) thought that her seizures might prove to be transient; and (5) were more concerned about her microcephaly—than about the post-immunization encephalopathy—as a potential cause of further CNS dysfunction.

SMD at 5. Dr. Bustion's affidavit states that he was present when Maggie was diagnosed, that Maggie was diagnosed as having an adverse reaction to the DPT shot and that treating physicians did not consider her condition to be the result of microcephaly.

Exhibit DD is the affidavit of Kay Whitecotton's obstetrician, Dr. Foltz, and concerns Maggie's condition at birth. In his affidavit, Dr. Foltz asserts that "Maggie was small but completely normal and not microcephalic." Petitioner submitted this affidavit to contradict the special master's finding "that Maggie was at least borderline microcephalic at birth and that she was clearly microcephalic by the time she received her third DPT shot." SMD at 7.

Exhibit EE is the affidavit of Dr. DeRosa, Maggie's orthopedist, and concerns her dislocated hip. In his affidavit, Dr. DeRosa asserts that Maggie's hip dislocation was not congenital, but secondary to muscle imbalance due to her cerebral palsy. Petitioner submits this affidavit to contradict the special master's finding that Maggie's hip dislocation was congenital. SMD at 10-11.

The final two items (exhibits HH & II) consist of excerpts from two medical treatises.[6] The discharge statement from petitioner's 1975 hospitalization stated that

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[6] Exhibit HH is taken from Menkes, *Textbook on Child Neurology*. Exhibit II is taken from Evans, *Manual on Child Neurology*.

extracted spinal fluid revealed evidence of a subacute central nervous system affliction with a demyelinating component. Petitioner's Exhibit F. These two treatises are offered to show that demyelination occurs in encephalopathies following DPT vaccinations.

B

The special master reviewed each of the exhibits discussed in part IIA and found that each piece of evidence either could have been discovered had petitioner used due diligence or would not materially affect the outcome of the case. Therefore, the special master determined that the evidence did not satisfy the criteria for relief under Rule 60(b)(2). We agree with the recommendation of the special master.

With the exception of Dr. Bustion, each of the doctors submitting affidavits were treating physicians who were known to petitioner prior to the evidentiary hearing. The common characteristic of each of these affidavits is that they contain information that could have been discovered by petitioner if she had used due diligence in preparing for the evidentiary hearing. The statements from each of these doctors were within the reach of the petitioner. There is no satisfactory explanation offered for petitioner's failure to include the observations now offered when her case was initially presented.

Dr. Bustion never treated Maggie and therefore was not mentioned in any of her medical records. Apparently after judgment was entered in this case, petitioner discovered that Dr. Bustion was present when Maggie was diagnosed during her 1975 hospitalization. Even if it is assumed that this evidence could not have been discovered earlier if petitioner had used due diligence, the special master, in his recommendation to this court, said that he did not consider Dr. Bustion's affidavit to be more credible than the contemporaneously written discharge diagnosis that it contradicts. This affidavit falls within the category

of evidence that merely impeaches evidence in the record but does not affect the result, and we agree with the special master that the written diagnosis itself is more credible than the more recent statements of Dr. Bustion.

Finally, exhibits HH and II do not constitute newly discovered evidence because the evidence is cumulative of evidence already in the record. Petitioner's expert, Dr. Kitts, testified that there is a demyelinating component in DPT reactions, Tr. at 128; that is exactly what petitioner attempts to show with exhibits HH and II.

Accordingly, we conclude that petitioner's motion for relief from judgment should be denied because each item proffered either is cumulative of evidence already in the record or fails the "due diligence" test.

III

Based on the foregoing, petitioner's motion under RCFC 60(b)(2) for relief from judgment is DENIED.

/s/ James T. Turner
JAMES T. TURNER
Judge

SUPREME COURT OF THE UNITED STATES

No. 94-372

DONNA E. SHALALA, Secretary of Health and Human Services, PETITIONER

v.

MARGARET WHITECOTTON, ET AL.

ORDER ALLOWING CERTIORARI

Filed October 31, 1994

The petition herein for a writ of certiorari to the United States Court of Appeals for the Federal Circuit is granted.

October 31, 1994

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